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ABSTRACT

Psychotherapy is an alien concept to many refugees from traditional cultures, since much of psychotherapy is tied to Western thoughts, practices, and belief systems. However, a variety of therapeutic strategies can be effective with refugees if modified to account for cultural factors. Four clinical intervention strategies are discussed with respect to their applicability to refugees: (1) crisis intervention; (2) cognitive behavioral therapy; (3) dynamic individual "relationship oriented" therapy; and (4) family and marital therapy. These approaches were selected based on their demonstrated cross-cultural utility and on general characteristics of refugee psychopathology and interpersonal dynamics. Suggestions are made regarding appropriate modifications to account for cultural factors within each approach. In addition, issues pertaining to the use of interpreters in psychotherapy are discussed, as well as general sources of difficulty in conducting psychotherapy with refugees. Finally, several approaches to treatment are described which were developed specifically for use with refugee or minority populations. References are included. (Author/TE)

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Psychological Interventions with Refugees

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ABSTRACT

Psychotherapy is an alien concept to many refugees from traditional cultures. Much of psychotherapy is tied to Western thoughts, practices, and belief systems. However, a variety of therapeutic strategies can be effective with refugees if modified to account for cultural factors. Four clinical intervention strategies are discussed with respect to their applicability to refugees; 1) crisis intervention, 2) cognitive behavioral therapy, 3) dynamic individual "relationship oriented" therapy, and 4) family and marital therapy. These approaches were selected based on their demonstrated cross-cultural utility, and on general characteristics of refugee psychopathology and interpersonal dynamics. Suggestions are made regarding appropriate modifications to account for cultural factors within each approach. In addition, issues pertaining to the use of interpreters in psychotherapy, as well as general sources of difficulty in conducting psychotherapy with refugees are discussed. Finally, several treatment approaches developed specifically for use with refugee or minority populations are described.

TABLE OF CONTENTS

INTRODUCTION. 5
THE PSYCHOTHERAPEUTIC CONTEXT 7
Psychotherapy Through an Interpreter 7
Linguistic Complications in Interpreted Psychotherapy 8
Training for the role of Mental Health Interpreter 8
Working with Interpreters 9
Interpersonal Dynamics of Interpreted Psychotherapy 10
Sources of Difficulty with Refugee Psychotherapy 12
INDIVIDUAL PSYCHOTHERAPY WITH REFUGEES 16
Crisis Intervention 16
What is a Psychological Crisis? 16
The Origins of the Crisis Intervention Approach 17
Goals of Crisis Intervention 17
General Characteristics of Crisis Intervention 18
Common Technical Characteristics of Crisis Intervention 19
Assessment in Crisis Intervention 22
Summary and Implications for Refugee Psychotherapy 23
Cognitive and Behavioral Therapy with Refugees 24
Refugee Psychopathology: Implications for Cognitive-Behavioral Therapy 26
Cross-cultural Application of Cognitive and Behavioral Techniques 28
Buddhist Cultures 28
Hispanic Cultures 29
Other Cultural Settings 29
Models for Applying Cognitive and Behavioral Therapies
with Refugees with Specific Disorders 31
Depression 31
Post-traumatic Stress Disorder 34
Grief 36
Other Anxiety-related Symptoms and Disorders 36

INTERPERSONAL APPROACHES TO PSYCHOTHERAPY WITH REFUGEES . . 38
Interpersonal Conflicts 38
Therapy for Interpersonal Difficulties 39
Individual Interpersonal Psychotherapies 39
Interpersonal Psychotherapy 40
Supportive-expressive Psychoanalytically Oriented Psychotherapy 41
Marital Therapies 42
Applying Marital Therapy to Refugees 42
Models of Marital Therapy 44
Psychodynamic marital therapy 44
Behavioral marital therapy 45
Structural-strategic marital therapy 45
Transactional analysis 45
Sexual dysfunction 46
Family Therapies 47
Use of Family Therapy with Refugees 47
Models of Family Therapy 50
Structural family therapy 50
Strategic family therapy 51
Behavioral family therapy 51
Family Therapy and Ethnocultural Influences 52
Group Treatment 53
TREATMENT APPROACHES DEVELOPED FOR MINORITIES AND REFUGEES . 54
Cuento Therapy 54
Ecological Structural Family Therapy 55
Family Effectiveness Training 56
Life Enhancement Counseling 57
SUMMARY 57
REFERENCES 60

INTRODUCTION

It may seem that a paper devoted to psychotherapeutic interventions with refugees is a questionable pursuit, even though many refugees have psychological problems, because psychotherapy is such an alien concept to them. How can an activity, such as psychotherapy, which is so tied to Western thought and practices, be applied with individuals with such differing beliefs, perceptions, and cultural experiences? Clearly the stresses associated with being a refugee and the requirements of adapting to a new, strange land are great. Many, if not most, refugees experience psychological symptoms which persist for long periods of time. Their traditional means of dealing with these problems are often unavailable, and, when available, may be ineffectual in the face of this new challenge. Western psychological treatment methods may be difficult for refugees to accept. It may be equally difficult for mental health professionals with linguistically and culturally different expectations to deal with patients who do not "fit" their model of a typical patient. However, intervention approaches widely taught and used in the United States remain the primary means the mental health professional has for dealing with the refugee's problems, and, as discussed throughout this paper, there is reason to believe that many of these methods can be effective if modified to account for cultural factors. These modifications serve both to increase trust and rapport in the therapeutic relationship (S. Sue & Zane, 1987), and to make the specific goals and processes of intervention appropriate and mutually acceptable.

Several authors have addressed the issues and problems of applying psychotherapy with the culturally different client in the past (Abel, Metraux, & Roll, 1987; Chien & Yamamoto, 1982; Lee, 1980; T. Y. Lin & M. C. Lin, 1978; Sato, 1975; D. Sue & S. Sue, 1972; S. Sue & Zane, 1987). Two recent reviews of the field have surveyed efforts to employ psychological treatment approaches with Asian Americans (Leong, 1986) and Southeast Asian Americans (Nishio & Bilmes, 1987). Most of these reviews and theoretical efforts have focused upon issues believed to influence efforts to adopt psychological treatment methods with culturally diverse individuals. This paper takes a different tack in that it explores how several treatment approaches, demonstrated to be effective in Western countries, might be applied with refugee clients. The clinical intervention strategies 1) crisis intervention, 2) cognitive behavioral therapy, 3) dynamic individual "relationship oriented" therapy, and 4) family and marital therapy, were chosen because the assumptions and tactics were considered applicable, with modification, with culturally different but troubled populations such as Southeast Asian, Hispanic, and other refugees.

A serious obstacle in preparing this paper was the lack of specificity and definition in accounts of refugee psychotherapy. In the literature to be discussed, guidelines are provided for establishing rapport with patients, and suggestions are made regarding appropriate clinician-patient roles, but little is provided in the way of therapy content. This lack of specificity is problematic

because it thwarts efforts to improve the science and art of treatment, and prevents the transfer of effective techniques and treatment models from one setting to another. Although providing such specificity and definition is difficult, we contend that efforts in this direction can and should be made.

The predominant model of treatment reported in the refugee literature consists of medication accompanied by "supportive psychotherapy." Supportive therapy, as described in various written accounts and by persons doing such treatments, may include one or more of the following aspects. The first is an emotional, caring, empathic component, not very different from the immediate care given emotionally distraught persons walking into a crisis center for help. This can be vital in terms of helping a person vent feelings and feel less isolated and hopeless, but is not usually sufficient to produce long-term improvement in a person with serious psychopathology. A second aspect includes efforts at problem solving and resolving target life issues, and may include giving advice, suggestions, and encouragement. This component may assist with a specific problem, but if problem-solving strategies appropriate to the new culture are not taught as well, the therapist may in essence be providing the client food rather than the tools to grow food. A third aspect may be aimed at improving social relationships within the family, within the refugee community, and with persons from the non-refugee community. Although such supportive interventions are useful in assisting a person through a crisis, and in helping with day-to-day dilemmas and problems, they do not have a great deal of demonstrated effectiveness against the serious disorders of depression and anxiety from which refugees in mental health settings commonly suffer.

The language of behavioral, cognitive, and other therapies may be used to describe many of the interventions subsumed under "supportive therapy," and new possibilities arise when interventions are viewed from within the context of these well-described methods. For example, methods for developing social skills and assertiveness, and for increasing problem solving skills have been well elaborated. In addition, methods of cognitive restructuring, reframing problems, and subjecting ones beliefs and fears to empirical tests are well described. These methods provide a context within which a large variety of content can be subsumed, and therefore are amenable to cross-cultural application by an imaginative clinician.

In the following sections several intervention techniques are described and potentially adaptive aspects of each is noted. Possible limiting factors in the adaptation of the techniques to refugees are also explored so that clinicians might better select the method most adaptable for the particular client or population being served.

THE PSYCHOTHERAPEUTIC CONTEXT

Psychotherapy Through an Interpreter

Providing psychological treatment services to non-English-speaking clients presents a daunting challenge to mainstream agencies and therapists, which has been addressed in a number of ways. Many agencies attempt to assign bilingual workers the task of providing psychological therapy, even though they may be inadequately trained. Other programs use bilingual paraprofessionals as co-therapists. One effective approach, though not without its own difficulties, is the use of trained interpreters. These various treatment models present strengths as well as weakness which are discussed in depth by Egli (1987). The focus of this section will be the issues and difficulties of conducting therapy through an interpreter.

The need for interpretive services, even when the patient is capable of communicating in English as a second language, has been noted by several authors (Acosta & Cristo, 1981; Egli, 1987; Marcos, 1976; Westermeyer, 1987a). Patients may be able to express factual information in a second language, but not affective or personal information. Persons who are experiencing high levels of stress, anxiety, depression, delirium, or thought disorders may lose their ability to communicate effectively in a second language (Peck, 1974, Westermeyer, 1987a). In addition, both under- and over-pathologizing can result from interviews conducted in the patient's second language (Del Castillo, 1970; Marcos, Alpert, Urcuyo, & Kesselman, 1973). There may be outright misunderstanding of words, contexts and gestures by the clinician, leading to over-pathologizing (Marcos et al., 1973). However, a person may respond in a more controlled way when interviewed in a second language, giving a poorer sample of speech for the clinician to analyze, and pathology may be missed (Westermeyer, 1987a). Acosta and Cristo (1981) note that hand and facial gestures, as well as congruency between verbal and non-verbal expression, increase when an interpreter is used with marginally bilingual Spanish-speaking clients.

There are four major concerns in working with interpreters (Marcos, 1979; Westermeyer, 1987a). The first concern involves the language expertise of the interpreters, and the linguistic complications they face. It can be difficult to find persons with adequate skill in both languages. The second major concern is the mental health knowledge of the interpreter. Mental health work involves complex linguistic, cultural and scientific concepts which the interpreter must comprehend well enough to guide accurate interpretation. The third concern is that the mental health professional must know how to work with the interpreter. Mutual courtesy and respect are necessary, and the professional should be aware of the interpreter's strengths and weaknesses. Finally, the interpersonal dynamics of the situation must be understood and managed effectively. These topics will be dealt with in turn.

Linguistic Complications in Interpreted Psychotherapy

In the mental health context, interpretation requires that the interpreter utilize his or her expertise and sensitivity with respect to the differing languages and cultures, interpreting meaning as well as words. A literal interpretation may be technically correct but miss a crucial point which is vital to mental health treatment. Subtle meanings, things left implied but unsaid, and culturally dissonant qualities of expression may be lost. At times, an interpreter may be required to provide elaboration to clarify a patient's meaning. However, these elaborations should be kept to a minimum, and in addition to the elaboration, the clinician should receive literal interpretation because the interpreter may not recognize clinically important material, or may consider certain important material irrelevant (Williams, 1985). In addition, the way a patient phrases something, such as using a very traditional vs. modern expression, may be of clinical interest.

Training for the Role of Mental Health Interpreter

Interpreters need to be familiar with basic mental health concepts (Ishisaka, Nguyen, & Okimoto, 1985; Tung, 1985; Westermeyer, 1987a). There are a number of dangers in psychiatric work through an untrained interpreter (Acosta & Cristo, 1981; Marcos, 1979). Sabin (1975) reported the suicide of two patients whose suicide risk was underestimated during an interpreted interview because the interpreters were not trained in mental health, and vital information was lost during the interpretation. Also, the clinician did not realize the significance of what was interpreted.

Relatively minor alterations of a statement can substantially alter the meaning of a patient's communication (Marcos, 1979; Price, 1975; Putsch, 1985). Price (1975) noted examples where the attempt of the interpreter to make a patient's reply more meaningful or intelligible actually masked the psychotic thought process of an hallucinating patient. Putsch (1985) provided examples of misinterpretation due to misunderstanding of terms, misleading paraphrasing, omission of details which the interpreter felt uncomfortable in repeating or which the interpreter felt were improper to repeat, and outright distortion of a physician's question in order to make it more culturally-acceptable to the patient.

At times, family, friends, clerical, or service staff are utilized as interpreters (Marcos, 1979; Putsch, 1985). This is a poor situation, and although it may be necessary as a stopgap measure for initial assessment, psychotherapy using an untrained person or family member as interpreter cannot be recommended. The results can be disastrous even during initial intake due to the inability of the interpreter to appreciate the problem, and to provide adequate translations (Sabin, 1975). Many difficulties occur when family members, friends, or untrained strangers perform the interpretation (Faust & Drickey, 1986; Marcos, 1979; Westermeyer, 1987a). Family members have a stake in the outcome of the interview and may tend to either enlarge or minimize the pathology of the patient

depending upon their personal agenda. In one case, a patient committed suicide who had received prior mental health consultation. The depth of the problem was not revealed because the interpreter was a relative and a factor in the patient's distress. Problems with using such persons have been addressed in greater detail elsewhere (Egli, 1987; Marcos, 1979; Santopietro, 1981; Westermeyer, 1987a; Williams, 1985).

Acosta and Cristo (1981) described an effective program for training interpreters for the Hispanic population. Their program included didactic training in mental health, and observation of audio and video taped therapy sessions. There was also special instruction about how to manage the therapeutic situation, including proper roles with respect to patient and clinician, dealing with transference, and maintaining a professional stance during emotional exchanges. Benhamida (1988) has described training programs at various levels for both spoken and sign-language interpreting, and discussed their application to interpretation in refugee mental health settings. Although there are not currently any formal training programs for refugee mental health interpreting, Benhamida discusses various training models that could be applied to the situation, and the major factors that have to be taken into account when tailoring such programs to the specific needs of an agency.

Working with Interpreters

Several authors have made suggestions regarding work with interpreters (Brower, 1980; Kinzie, 1985a, 1985b; Santopietro, 1981; Tsui & Schultz, 1985; Westermeyer, 1987a). Santopietro (1981) recommends using simple sentences, and sentence-by-sentence interpretation during an interview. The clinician should speak directly to the patient, not to the interpreter. The expertise of the interpreter should be utilized to help the clinician understand client behaviors, and to help the clinician phrase questions appropriately. Faust and Drickey (1986) recommend using a quiet, unhurried approach, and asking for a "cultural interpretation" when necessary.

One must be alert to a tendency in some interpreters to stray from agreed-upon agendas, to give advice, criticism, and guidance to patients without informing or getting the consent of the clinician. With appropriate training, this should not be a major problem. It can arise, however, when the cultural values of the interpreter are at odds with the suggestions of the clinician, or when the worker is inexperienced or untrained in the task. Such topics as wife or child abuse and the appropriate actions to take in such cases may pull the clinician and worker into cultural conflict.

In spite of the problems working with interpreters, Westermeyer (1987a) noted that there can be advantages to the interpreted interview. One advantage is the opportunity for the clinician to reflect on what has been said, to consider how to proceed, and to observe non-verbal behaviors while the interpreter and patient are speaking. Another advantage comes when the clinician and interpreter have been working extensively together, have a great deal of mutual trust, and can

operate as "a highly effective and efficient team, much like a surgical team." Kline, Acosta, Austin, and Johnson (1980) found that Spanish-speaking patients felt more satisfied with their interviews and more happy with the help received when interviews were conducted using interpreters than when they weren't used. However, the clinicians felt the interpreted interviews were less satisfactory than non-interpreted ones, and erroneously thought the patients felt less understood and satisfied as well.

The cultural knowledge and expertise of an interpreter can be invaluable for a clinician (Acosta & Cristo, 1981; Faust & Drickey, 1986). An interpreter may be relied upon to put patients' remarks in a cultural context, and to assist the clinician to determine if a patient's ideas, behaviors and responses are congruent or not with respect to the culture (Westermeyer, 1987b), although this may best be left until after the interview, and should not go beyond the expertise of the interpreter. In addition, the interpreter can inform the clinician of potential negative consequences of asking questions which may seem very inappropriate to the patient, or asking them before sufficient trust has been established. Questions on such topics as sexual matters or traumatic experiences must be pursued carefully and with sensitivity (Faust & Drickey, 1986; Hoang & Erickson, 1985; Ingall, 1984).

Trained interpreters can help the clinician to explain and clarify treatment plans and goals to patients and their families in ways that will increase compliance with treatment. Achieving treatment compliance is frequently problematic (Breitenbucher, 1980; Kemp, 1985; Kinzie, 1985b). For example, Kinzie (1985a) reported that it is very difficult to explain the concept of maintenance medication to Southeast Asian clients, and that such clients frequently stop taking medication as soon as some improvement is noted, or in response to side effects. Other problems in compliance may reflect the very different outlook on mental illness that refugees have when compared to the Western practitioner (Ishisaka et al., 1985; Kinzie, 1985a; Tung, 1985).

Interpersonal Dynamics of Interpreted Psychotherapy

Work involving interpreters allows for a very complex interplay of interpersonal dynamics. In addition to the triad, there are the three dyads of patient-interpreter, interpreter-clinician, and patient-clinician. (Faust & Drickey, 1986; Westermeyer, 1987a). Critical aspects of the interpreter-patient relationship may involve extra-clinic influences. For example, in a tight-knit refugee community, the patient may well be acquainted with either the interpreter or members of the interpreter's family, and be reluctant to divulge personal, possibly embarrassing or shameful information. As a general rule, the interpreter should not be personally involved with the client outside the treatment situation (Richie, 1964). Other problems may occur when the interpreter and patient are of different sex, social status, if the interpreter is younger than the patient, or if the interpreter is unmarried and the patient is concerned with issues related to marriage (Faust &

Drickey, 1986; Ingall, 1984; Kemp, 1985; Santopietro, 1981; Westermeyer, 1987a). These same disparities, such as age, sex, marital status, education, and social class can operate to thwart the clinician-patient relationship as well (Westermeyer, 1987a).

The quality of the interpreter-clinician relationship is vital. Baker (1981) quotes a resettlement worker as saying "It is more important to have a good relationship with your interpreter than with your spouse" (page 393). The stability of a team and the mutual trust which can develop from having worked together over a long period of time is extremely valuable. There can be difficulties with respect to the difference in status between clinician and interpreter (Baker, 1981). It is frequently the case that refugees, upon arrival, must accept employment in a much lower status job than they had in their country of origin. For example, refugee physicians have had to take jobs as interpreters or paraprofessionals, a highly significant drop in status. This will create friction if the professional appears to lack respect for the interpreter.

The same dynamics that operate between interpreter and patient may operate between clinician and interpreter. For example, a male interpreter may have difficulty respecting the authority of a woman therapist, and an older interpreter may have difficulty respecting a younger clinician. The same may be said about the clinician's attitude and trust of the interpreter. In addition, subtle and semi-conscious cultural biases may interfere with the clinician-interpreter relationship (Westermeyer, 1987a). Westermeyer (1987a) recommends that clinicians contemplating cross-cultural work carefully review their own biases toward those they are working with.

A problematic aspect of the patient-clinician or patient-paraprofessional relationship concerns issues of transference and countertransference. Transference refers to the projection of feelings and attitudes by the patient upon the therapist based on previous experiences of the patient. Countertransference refers to such projections by the therapist onto the client, and more generally to the feelings toward the client aroused during treatment. For example, the history of the Vietnam war may influence the approach of Western therapists to Vietnamese patients, and of Vietnamese patients who had unpleasant war or refugee experiences to the American clinician (Brower, 1980).

The issue of transference between patient and clinician has been discussed in the literature on psychotherapy with the deaf (DeMatteo, Veltri, & Lee, 1986). Interpreters are prime candidates for transference, since they are present in all sessions and reveal little of their own nature, thought, or feelings to the patient. In addition, the patient may displace hostile feelings from the therapist on the interpreter. This phenomenon was also noted with Spanish-language interpreters by Acosta and Cristo (1981).

A serious problem in the process of history-taking and treatment is the clinician and/or interpreter's inability to deal emotionally with the horror stories they hear from refugees who suffered particularly traumatic experiences (Kinzie, 1985b; Kinzie, Fredrickson, Rath, Fleck,

Karls, 1984). The difficulty in listening to and responding to these stories is compounded for interpreters for whom the tales bring back memories of their own experiences. For example, if an interpreter witnessed the death of his/her spouse or children, having to listen to and repeat the similar story of a patient can bring back forcefully their own experience, with intrusive images, thoughts and affect. For survivors acting as interpreters, listening to these stories can be very painful, leading to an understandable reluctance to discuss these events with the patient. This represents a problem because a thorough history is a prerequisite of quality care and assessment, and because treatment may require discussing the traumatic events (Kinzie, 1981, 1985a, 1986; Kinzie et al., 1984). This is another area in which interpreters require training (Acosta & Cristo, 1981). Professional ethics demand that a clinician not subject an untrained interpreter to a potentially emotionally damaging experience.

A final point is the matter of confidentiality, which can be a difficult concept to explain both to the interpreter and the patient. The notion that information should be kept from relatives of the patient, particularly elders, is a foreign one among many refugee groups. In tightly knit refugee communities, there is also a fear that information gained might spread through the community. If such were to happen, the ability of an agency to function effectively would be severely compromised. Careful training in the area of confidentiality is necessary.

In summary, use of interpreters presents obstacles which can be overcome. The psychological treatment literature makes it clear that interpreters can work effectively in a mental health setting when training is adequate. When interpreters are available, utilization as well as satisfaction with service increases (Acosta & Cristo, 1981). The lack of bilingual mental health professionals should not discourage non-refugee mental health professionals from attempting to provide quality service to refugees or other ethnic minorities.

Sources of Difficulty with Refugee Psychotherapy

In addition to the language barriers discussed above, there are several other unique sources of difficulty in conducting psychotherapy with refugees. Some of these pertain to all instances in which a refugee is seen for psychotherapy, while other obstacles are more typical of specific refugee groups. In general, these difficulties may be divided into those that are attributable primarily to the therapist as opposed to those that stem from particular characteristics of the refugee.

Among the sources of difficulty attributable to the therapist, the most serious and potentially detrimental obstacles occur when the therapist holds unfounded stereotypic and prejudicial views concerning the refugee's race or ethnic group. In most cases of refugee psychotherapy the therapist is likely to be of western origin, while more often than not the refugee will be of some

non-western origin and very likely a member of a different race or ethnic group. Kinzie (1981) has noted that in working with Indochinese refugees, American psychotherapists may hold prejudicial views that lead to counter-transference problems. Such views may reflect negative feelings concerning the Vietnam War and its outcome, or they may be part of a general stereotype the therapist holds concerning the refugee's ethnic group. A study by Bloombaum and Yamamoto (1968) demonstrated quite convincingly that psychotherapists are far from being immune from holding cross-cultural stereotypes. Whatever the source of a prejudicial attitude, the end result is a less accurate picture of the refugee as an individual, and unavoidably, a less than fully beneficial psychotherapeutic encounter for the refugee.

Hamilton (1979) notes that in most cases unfounded stereotypes appear where a true and genuine understanding of a specific group or culture is lacking. Refugee stereotypes are no exception to this rule. Thus, a second source of difficulty in refugee psychotherapy is ignorance on the part of the therapist concerning his or her client's cultural background. In their analysis of why Asian clients often do not become engaged in therapy, Tsui and Schultz (1985) note that "...treatment failure often results directly from the therapist's unfamiliarity with salient cultural issues, which leads to the failure to establish rapport and the subsequent therapeutic alliance crucial to the treatment process" (p. 561). Kinzie (1981), referring to Southeast Asian patients, elaborates further on this issue:

> The western-trained psychiatrist has values often at variance with those of the refugee. He lives for the future rather than the past, prefers doing rather than being, conquers and attacks nature and problems rather than docilely accepting the situation, and prefers individualism to the dominance of the family. (p. 252).

Though perhaps somewhat exaggerated, Kinzie's observations do point toward some general tendencies among Southeast Asian refugees which may appear to be abnormal in the eyes of a therapist who has no knowledge of Southeast Asian culture. This is not to say that such knowledge, when possessed, should be applied blindly to all refugees of a certain ethnic origin, but only to point out the necessity that a therapist working with refugees obtain a sufficient familiarity with his or her client's culture in order to determine whether a certain behavior, attitude or emotional reaction is in line with the refugee's, rather than the therapist's, cultural norms.

Therapists are not the only ones who may approach the therapeutic encounter with stereotypes and misconceptions. Kinzie (1985b) observed that "simply being referred to a psychiatrist means to many refugees that they are 'crazy'. This has a widespread cultural consequence for them and becomes a serious problem" (p. 51). This problem has two separate components. First, many refugees view any psychological difficulty as a sign of insanity, without distinguishing between types and degrees of maladaptive behavior. Second, this dichotomizing

viewpoint of sane versus insane results in a strong reluctance to seek professional help in dealing with what might otherwise be minor and quite easily overcome psychological difficulties. This often-times results in a compounding of difficulties. Those who do overcome their reluctance to seek professional help, usually approach psychotherapy with a great deal of fear and apprehension that may be unrelated to the specific difficulty that led them to require psychotherapy. Thus, in refugee psychotherapy the therapist must be able to clearly distinguish between anxiety about being in therapy, and that related to the client's particular psychological difficulties, though both sources of anxiety must clearly be addressed in the ensuing psychotherapy.

Refugees' reluctance to admit psychological difficulties frequently results in the expression of such difficulties through somatic symptoms. Tsui and Schultz (1985, p. 563) made the following observations in this context:

> Asian clients often present physical symptoms as the key treatment issue, playing down psychological symptoms. Such expression is partially a manifestation of the Asian holistic emphasis of the union of the mind and body, the individual reaction to stress with bodily as well as with psychological complaints. Further, since strong emotional expression is culturally discouraged, physical complaints easily become a vehicle for the acceptable expression of psychic distress... A depressive symptom may be expressed as difficulty with constipation, headaches or general lassitude. Such concretization can hinder the intake process and impede the development of a therapeutic alliance because the client expects the therapist to diagnose a physical malady, provide a prescription, or at the very least proffer advice related to somatic symptoms.

Thus, the tendency on the part of refugees to substitute somatic for psychological symptoms not only hampers diagnosis but also seriously interferes with any attempt to conduct psychotherapy, since in such cases refugees expect quick "medicine-like" remedies to their difficulties and reject psychological interpretations of physical symptoms. This rather widespread tendency among Southeast Asian refugees led Kinzie (1978) to the conclusion that the medical model is the most appropriate approach to refugee psychotherapy. He suggests that by assuring the refugee that a medical "cure" will be offered, and initially addressing only somatic aspects of his or her difficulties, one may gain the refugee's confidence, in which case he or she may then be more open to discuss psychological difficulties as well. Kinzie (1978, p. 514) describes the following case as a successful application of this approach:

> The patient, a laborer of mixed Asian ancestry, was referred to me because of his complaints of stomach pains, which were unresponsive to previous medical treatment. He had been told that the problem was all in his head. As I examined him he continued to talk about his pain which made it difficult for him to continue his work. The treatment included a physical

examination for his pain, recognition of the sickness he was currently experiencing and a brief sick leave from work. This approach made it possible for him to open up in subsequent sessions and to begin to talk about the deteriorating relationship with his wife. After a few sessions there was a marked diminution in his pain and he was able to return to work.

This case report illustrates the importance of gaining the refugee's trust before attempting to deal with sensitive issues. Whereas in traditional psychotherapy it is assumed that the client has come to discuss sensitive, delicate, and intimate issues, in refugee psychotherapy the therapist must be careful not to express doubts concerning the refugee's physical symptoms and convey to the refugee a sense of trust and belief in what he or she is reporting before attempting to deal with possible underlying causes.

A related source of difficulty in refugee psychotherapy is some refugees' reluctance to express, or even acknowledge having negative thoughts and feelings concerning parents and other family members. This strong taboo renders the conduct of psychodynamically oriented therapy almost impossible with many refugee groups. The therapist must be keenly aware of indirect, perhaps non-verbal, expressions of familial discord, and if these are detected, attempt to create a context within which the refugee may feel comfortable enough to discuss these issues, perhaps even hypothetically or in terms of a "third party" experiencing such problems in his or her family.

In sum, we have noted five potential sources of difficulty in the conduct of refugee psychotherapy:

1. Unfounded stereotypes and prejudices, on the part of the therapist, concerning the refugee's race or ethnic group which may result in counter-transference and/or difficulties in perceiving the refugee as a unique individual.
2. A lack of knowledge and understanding, on the part of the therapist, of the refugee's cultural background, and what are considered normal and abnormal behaviors attitudes and emotions within the refugee's cultural milieu.
3. The stigma attached to psychological difficulties in some cultures creates a reluctance on the part of refugees who come from that culture to admit and address psychological difficulties.
4. As a result of stigmata associated with psychological problems, some refugees tend to express such difficulties through physical symptoms and expect treatment to be addressed exclusively to these symptoms.
5. Expressions of negative feelings toward family members are strictly forbidden in some cultures. Consequently, such issues must be approached with the utmost care, sensitivity, and discretion on the part of the therapist.

INDIVIDUAL PSYCHOTHERAPY WITH REFUGEES

Crisis Intervention

For several reasons, crisis intervention is one of the most vital treatment approaches to refugee psychotherapy. As Williams and Westermeyer (1986) noted, Erich Lindemann's (1944) description of how individuals respond in crisis situations is a useful conceptualization and treatment framework for the experiences of today's refugees. Williams (1987), suggested that crisis intervention services be readily available to refugees in camps and during resettlement both for primary prevention and early treatment (secondary prevention). Bromley (1987) has discussed the adaptation and application of crisis intervention techniques for use with traumatized Cambodian refugees.

One benefit offered by crisis intervention stems from the above-noted reluctance on the part of the refugee to seek mental health care. When they finally seek treatment, they are likely to be in a state of crisis requiring immediate attention. The processes of becoming and then being a refugee are laden with numerous traumatic and stressful experiences (Ben-Porath, 1987a), any of which may require crisis intervention. Many refugees experience the symptoms of Post Traumatic Stress Disorder (Garcia-Peltoniemi, 1987), which, at least initially, may best be dealt with by some form or another of crisis intervention. Given the apparent relevance of this form of psychotherapy for refugees one might expect to find a rich and extensive literature on crisis intervention with this population. However, with the exception of the Bromley (1987) article on Cambodians, such a literature is virtually non-existent. Thus, rather than discuss the specifics of refugee crisis intervention, we will present an overview of crisis theory and approaches in general, and suggest possible applications and modifications pertaining specifically to refugees.

What is a Psychological Crisis?

Caplan (1961) defines a crisis situation as one that occurs "when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem-solving" (p. 4). Thus, a crisis is said to occur whenever a person finds him or herself in a strongly undesirable situation and lacking either the ability or knowledge of how to cope with that particular situation. Crisis-provoking situations range from the need to make an important decision to the experience of strong and uncontrollable emotions. The crisis is usually followed by a period of disorganization and confusion resulting in unsuccessful attempts to cope with the given situation. Caplan (1964) delineated four often-found phases of a typical crisis situation:

1. A crisis begins to develop and the individual begins to experience emotional tension and disorganization. The individual initially attempts to deal with the situation with previously learned coping mechanisms.

2. Coping efforts fail to resolve the problem leading to increased feelings of tension and anxiety. This phase may be particularly salient in refugee crises. Refugees find themselves experiencing these difficulties in a new and foreign land, often-times lacking their previously relied upon support system which consisted of their extended family, and thus faced with a situation with which they are unable to cope.

3. The third phase is characterized by a substantially increased level of tension and further attempts to mobilize internal and outside resources.

4. Finally, if intensified attempts fail to resolve the problem and lower the level of tension, extensive personality disorganization and perhaps even emotional breakdown may occur.

The Origins of the Crisis Intervention Approach

Koss and Butcher (1986) pointed out the first formal use of crisis intervention methods occurred during World War II when a large number of soldiers developed stress-related symptoms and short-term treatment programs were designed to provide treatment as soon as possible after the initial breakdown had occurred. This early form of crisis intervention was aimed at stress-reduction, symptom relief, and prevention of further breakdown by helping the individual to restore self-esteem and avoid further maladjustment. This approach was unique in that it represented a sharp departure from the previously held notion that a crisis situation was only a manifestation of a "deeper" problem, and that treatment should be directed toward the deeper long-term problem rather than to coping with the specific crisis situation at hand. Crisis intervention developed when it was realized that psychodynamic approaches were not always feasible nor desirable in dealing with certain areas and instances of psychological difficulties.

This change in emphasis is an important one for refugee psychotherapy. Given refugees' hesitance concerning psychotherapy, it is clear that a therapeutic approach that addresses specifically defined and restricted issues will be more acceptable than one that attempts to uncover deeply rooted conflicts and complexes with a strong emphasis on psychodynamics. As noted above, refugees are often highly reluctant to discuss family difficulties which so often are the focus of psychodynamically oriented psychotherapy. This is not to deny the importance of such issues, but only to suggest that with refugees, as with soldiers in combat, there are certain crisis situations that are best handled by focussing therapy directly on the crisis at hand.

Goals of Crisis Intervention

By its very definition, the goals of crisis intervention are limited and circumscribed. Butcher, Stelmachers and Maudal (1983) discuss four general goals of crisis therapy:

1. Symptom Relief: The first and foremost goal of any crisis intervention is to deal directly and immediately with the specific problem that led the patient to seek help.

2. Restoration of Previous Level of Adjustment: Crisis intervention is directed toward restoration of the client's level of adjustment prior to the crisis. This, obviously, is not to say that an improvement in level of adjustment should not be encouraged during crisis therapy and perhaps recommended as a goal for follow-up therapy. However, the direct goal of crisis intervention is restoration of previous level of functioning by: (a) preventing further decompensation; (b) evaluating prior level of functioning; and (c) guiding the client in dealing with the crisis up until the point where previous level of adjustment is achieved.

3. Gaining an Understanding of Precipitating Factors: Analyzing and understanding the factors that led to the crisis situation serves several important functions: (a) Helping the therapist understand the nature of the crisis; (b) Helping the therapist understand the client's susceptibility to certain stressors; (c) Demonstrating to the client that his or her problem has a rational source and explanation; (d) Instilling in the client an understanding for his or her susceptibility to certain stressors; and (e) Providing the client with more adaptive mechanisms with which to cope with such stressors should he or she be faced with a similar situation.

4. Gaining an Understanding of the Client's Personality Characteristics Which Led to the Crisis: This goal of crisis intervention has the same functions as those described for understanding precipitating factors, but from the perspective of understanding how the client's personal characteristics made him or her susceptible to experiencing a crisis as the result of the factors which precipitated it. Even when catastrophic precipitating factors are present, personality characteristics may play a role in the degree of debilitation and the rate and extent of eventual recovery.

These general goals characterize many forms of crisis intervention although, as described below, some cases may involve more limited goals that may be accomplished in one therapeutic session.

General Characteristics of Crisis Intervention

Crisis intervention may be conducted at different levels of interaction between the therapist and client. Jacobson, Strickler and Morely (1968) noted four such levels:

1. Environmental manipulation -- Here, there is no direct interaction between therapist and client, but rather some form of intervention on the part of the therapist that is aimed directly at dealing with the source of the crisis rather than how the client might be coping with it.

2. General support -- Here, the therapist engages in active listening without threatening or challenging the client. A therapist utilizing this approach will help the client air his or her difficulties in an attempt to provide a better understanding of the situation.

3. Generic approach -- Under this approach intervention is more direct, with the therapist offering specific suggestions on how to deal with the crisis. However, this approach is guided by the assumption that every crisis situation has its specific treatment irrespective of the personality of the

client, and consequently, no need is seen to assess the client's personality in designing an approach to dealing with the crisis.

4. Individual approach -- According to this approach the interaction between person and situation must be considered in designing an appropriate coping strategy for the client. Thus, both the situation and the personality of the client need be specifically assessed before implementing a therapeutic program.

Which of these approaches is most appropriate for refugees? There is no "cook-book" answer to this question. Clearly, they become more intrusive from level to level, and thus, a general rule of thumb is that the least intrusive approach needed to deal with the specific crisis at hand should be adopted. In making this choice the therapist must bear in mind the above-noted difficulties associated with refugees' reluctance to discuss personal matters, and more specific cultural characteristics of the refugee. For example, Brower (1987) reports that it is important, when working with Cambodian refugees, to provide opportunities for the client to discuss their unique perspectives, values and coping styles, and to intervene in ways which emphasize coping skills rather than pathology, and which are respectful of cultural propriety in interpersonal relationships.

Common Technical Characteristics of Crisis Intervention

Though the specifics of crisis situations will invariably differ from case to case, we can clearly note some common technical characteristics of almost all crisis intervention approaches and situations. Koss and Butcher (1986) describe nine such characteristics some of which apply to all levels of crisis intervention while others characterize only the more intrusive applications of this approach:

1. Time: Due to the nature of crisis situations, crisis intervention is brief. Many therapists recommend telling the client during the first session that therapy will be brief and time-limited. Koss and Butcher (1986) note that informing patients of the specific time limits accomplishes three goals: (a) It confronts the client with the need to begin immediately to address the crisis situation; (b) It conveys the message that the therapist is confident that improvement is possible in a relatively short time; (c) It provides a set of shared goals concerning what therapy can and can not do. Owing to the time-limited nature of crisis intervention the first session is of crucial importance to the success of therapy. Butcher et al. (1983) identify several specific objectives that must be accomplished within the space of the first interview: (a) Establishing a constructive relationship with the client; (b) Gathering assessment information necessary for treatment planning; (c) Arriving at a tentative formulation of the problem and its causes; (d) Giving the client some perspectives on the problem, including an understanding of his or her adaptive and maladaptive coping mechanisms in relation to it; (e) Exploring new adaptive ways the patient can deal with the

problem; (f) Arriving at a strategy for achieving the agreed upon goals and making a therapeutic contract if additional sessions are planned; and (g) Arranging for future visits. Butcher et al (1983) find that whether crisis intervention will terminate with one session, or require further crisis therapy should be determined based upon the following factors: (a) Workability -- Can the individual resolve his or her problems by themselves; (b) Capability of self-examination -- can the client adequately determine whether a crisis has been properly dealt with; (c) Motivation -- Does the client possess the motivation to cope with the crisis; (d) Accessibility -- Is the client being seen therapeutically in another setting; (e) Advisability -- Are there further issues that need be addressed (in addition to those dealt with in the initial session); (f) Treatment history -- Is the client a "doctor-shopper"?

2. Limited Goals: Crisis therapy usually addresses clearly delineated and limited goals: (a) Removal or amelioration of the client's most disabling symptoms as rapidly as possible; (b) Prompt reestablishment of the client's emotional equilibrium; and (c) Development of the client's understanding of his or her current difficulties and increased coping ability in the future.

3. Development of a Working Alliance: Given the above-mentioned time constraints a cooperative atmosphere is crucial since there is not enough time to deal with issues of negative transference and counter-transference. Developing a working alliance with refugees is particularly difficult owing to numerous cross-cultural obstacles that may, at first, be found in the way of forming an adequate therapeutic relationship. Thus, particular attention should be paid to this aspect of crisis intervention when it is employed with refugees.

4. Maintenance of Focus: The focus of therapy is determined during the first session and actively maintained throughout therapy (barring unforeseen circumstances which may require a shift or deviation from original goals).

5. High Therapist Activity: In contrast to other forms of therapy, where the therapist may, at least initially, be very passive and leave it up to the client to determine the nature of each session, in crisis intervention from the very first session the therapist is more directive, actively explores areas of interest, formulates plans of action for the client to follow, assigns homework, and teaches problem-solving. Such an approach may be far more acceptable to a refugee who expects prompt and well defined action and might be intimidated and at a loss in the face of a deep and penetrating silence practiced in some forms of psychotherapy.

6. Rapid, Early Assessment: Crisis intervention requires extensive exploration and information gathering during the first therapeutic session. Specific issues will be discussed below.

7. Therapeutic Flexibility: Crisis intervention addresses a wide range of problems and crises, and thus necessitates a more flexible and eclectic therapeutic orientation on the part of a crisis intervention therapist. Therapeutic flexibility takes on an added meaning when dealing with

refugees, in which case a therapist must also be open to cross-cultural differences in the expression and management of crisis situations.

8. Promptness of Intervention: Crisis intervention should be provided as early as possible after the initial request when the client is most susceptible to, and most needy of treatment. This is particularly important in treating refugees who might be willing to accept psychotherapeutic intervention only at a moment when they feel totally overcome by the crisis situation.

9. Encouragement of Ventilation: The therapist attempts to develop an atmosphere in which the client feels safe and accepted, and in which he or she can express feelings and experience catharsis spontaneously and naturally. Due to some refugee groups' reluctance to express any form of strong emotions, acquiring a refugee's trust is crucial for him or her to be able to overcome their natural reluctance, and experience the emotional release that is sometimes necessary in effectively dealing with crisis situations. Brower (1987) reported the use of art as an indirect means to enable expression of feelings in a Cambodian man, which prevented him from losing face. She reports that in Cambodians, the inability to control emotion is seen as weakness, and therefore encouragement of ventilation should be handled very delicately, respectfully, and without pressure.

Butcher et al. (1983) describe the following specific tactics as useful in most cases of crisis intervention:

1. Offering emotional support.
2. Providing opportunities for catharsis.
3. Communicating hope and optimism.
4. Being interested and actively involved.
5. Listening selectively for key problems and issues.
6. Providing factual information.
7. Formulating the problem situation.
8. Being empathic and open to the patient.
9. Predicting future consequences.
10. Giving advice and making direct suggestions.
11. Setting limits to minimize destructive behavior.
12. Clarifying and reinforcing adaptive coping mechanisms.
13. Confronting the client when he or she is resisting.
14. Making concrete demands.
15. Working out a contract.
16. Enlisting the aid and cooperation of others.

All of these tactics may be useful in conducting crisis intervention with refugees.

Assessment in Crisis Intervention

As in any form of psychotherapy, gaining the best possible understanding of the client is crucial to the success of crisis intervention. Butcher et al. (1983) find the following nine assessment issues to be particularly pertinent to crisis intervention:

1. Determining whether or not the client can be adequately assessed at the time. This is a crucial issue in conducting crisis intervention with refugees. In addition to the obvious problems associated with the frequent need to employ an interpreter (and thus the need for one to be available) there are specific methodological difficulties related to psychological assessment with refugees. In most cases, standard assessment instruments have not been adapted for use with refugees thus leading to questions concerning the availability of adequate norms, and the reliability and validity of these instruments when used with refugees (Ben-Porath, 1987b). This is not to suggest that assessment can not be carried out with refugees, but only to point out the need for the clinician to employ a greater degree of clinical judgement in determining whether assessment is possible, and how much weight to give its results.
2. Gathering demographic information. This is particularly important in determining the refugee's potential sources of support and assistance in overcoming the crisis.

Given the vital importance of extended family in most refugee cultures, it is especially important to gain a rapid understanding of the current situation of both immediate and extended family. The sense that the "world is falling apart," characteristic of the crisis situation, may be reflected in a family which is the scattered across the globe with little hope of further reunion. Stress associated with having family members still in refugee camps, killed, missing, or living in the native country under difficult conditions can increase reactivity to stress and decrease ability to cope, especially in the face of loss or threats to loss of current relationships.

3. Obtaining information from outside sources. For example, obtaining corroborating or additional information from family members and acquaintances.
4. Identifying the direct precipitator(s) of the crisis. What was the specific chain of events that led the client to require crisis intervention. This will be the main focus of therapy.
5. Assessing the current level of functioning in terms of appearance and behavior, speech and verbal behavior, and thought content. In this area of assessment an adequate understanding of what is normal and abnormal in the refugee's culture is crucial to gaining an accurate perspective on his or her current level of functioning. Exact and full interpretation are equally important if translation is necessary.
6. Observing the client's emotional state. Does the client manifest signs of depression, anxiety, etc.

7. Observing the client's manner of relating. Is the client capable of communicating her/his difficulties and benefiting from outside support.

8. Assessing premorbid adjustment as distinct from current stress. Although this can be particularly problematic with refugees, an assessment of prior educational and vocational achievement within the context of the client's native culture can provide valuable information. Talking with family members, who will frequently accompany the client to treatment, is also of great help in this area, and can help in establishing vital trust and rapport with the client's support system.

9. Making successive assessments in monitoring progress in therapy. Reassessing the client's level of functioning, emotional state, and manner of relating (as defined above) as therapy progresses.

Summary and Implications for Refugee Psychotherapy

As noted throughout this section, crisis intervention is a particularly useful form of psychotherapy for refugees because of its supportive intent and restorative purpose. Its highly structured and directed nature makes it less threatening to those who for cultural reasons are intimidated by more intrusive verbal-personal forms of psychotherapy. By acknowledging the existence of a crisis, and identifying its precipitating factors, this form of therapy assigns a causal role to external rather than internal influences. This characteristic of crisis intervention may help alleviate some of the fears and culturally mediated negative connotations associated with the experience of emotional difficulties in some refugee cultures. Even the name crisis intervention may, for some groups, be less threatening than other forms of intervention containing the word therapy in their title.

Crisis intervention's time and goal limited nature also offer some important benefits for refugee psychotherapy. By clearly delineating the goals of intervention and the time frame within which these goals will be achieved, and by taking the lead and helping to maintain the focus of psychotherapy, the therapist offers his or her refugee client a sense of organization and order, in what otherwise may be a highly confusing and disorienting life situation.

As noted above, some refugees are highly reluctant to engage in any verbal form of psychotherapy due to the stigmata associated with psychopathology in their culture. Thus, those that eventually seek or are referred for psychotherapy are usually in a state of crisis requiring immediate attention. The prompt and immediate nature of crisis intervention make it particularly suitable for such cases. These same cultural restrictions often-times prohibit the overt expression of emotions in general and negative ones in particular. Crisis intervention offers the refugee an opportunity to ventilate and express his or her frustrations, difficulties, and emotions in a warm and emotionally supportive environment that is geared toward problem solving rather than

personality rebuilding. As such, it not only provides refugees with a much-needed emotional cushion, it may also help dispel previously held misconceptions and bring about a greater degree of openness toward the mental health system in general for those who need further treatment.

Cognitive and Behavioral Therapy with Refugees

This section examines the potential utility of cognitive and behavioral therapeutic approaches with refugees. The use of these approaches has not been reported with refugees or in most cultures from which the United States has recently received refugees. Therefore, the purpose of this section will be to suggest the possibility of applying these techniques with refugees, and to promote discussion and research which will guide their future cross-cultural adaptation and application. The literature on psychotherapy with refugees tends to focus on broad cultural issues, on the proper roles for professional figures to adopt, and on pitfalls to be avoided in interaction with clients (Acosta, Yamamoto, & Evans, 1982; Chien & Yamamoto, 1982; Ishisaka et al., 1985; Kinzie, 1981, 1985a, 1985b; Kinzie, Tran, Breckenridge, & Bloom, 1980; Leong, 1986; Tung, 1985). Often this information is presented in a way which compares "Western-oriented therapy" to what the authors consider culturally-appropriate and effective therapy approaches with refugees and ethnic minorities. Western psychotherapy is presented as being non-directive, passive, empathetic, and concerned with emotions and emotional reactions. In contrast, therapists working with refugees are usually encouraged to be active, authoritative, and prepared to deal with concrete aspects of the patient's life rather than focusing on personality change and emotional complaints.

This representation of Western therapy ignores the rapidly rising importance of behavioral and cognitive therapies which have had a major impact on the field of psychological intervention over the last several decades. There is a danger in deciding that Western-derived therapies will not work with refugees, and believing that one must start over from the beginning. Rather, it should be remembered that there is a great variety in Western psychotherapies, and important recent innovations should not be dismissed too quickly. Outcome studies have demonstrated that cognitive and behavioral therapies are frequently our most efficacious therapies for depressive and anxiety disorders (Beck, Rush, Shaw, Emery, 1979; Emmelkamp, 1986; Hollon & Beck, 1986). It is likely that similar effectiveness could be obtained with refugees if the linguistic and cultural issues could be resolved.

In this section, we will describe briefly the various models and techniques of cognitive and behavioral treatments, review the cross-cultural use of these methods, consider the theoretical and cultural issues which make the treatments more or less adaptable cross-culturally, and discuss issues in their application to refugees on a disorder-by-disorder basis. Since there are no specific data available to guide this discussion our comments should be considered suggestive and

provisional. However, these behavioral methods have a rich and broad history with many types of patients. The basic premise is that cognitive and behavioral therapies represent some of our most efficacious and adaptable psychotherapeutic techniques. Attempts to provide refugees with effective care should include adapting and applying cognitive and behavioral methods to meet their treatment needs.

Behavioral therapies have been extensively reviewed in the literature (c.f., Garfield & Bergin, 1986; Rimm & Masters, 1979; Turner, 1984). Behavioral methods include specific techniques, such as in vivo exposure, desensitization, modeling, covert and overt rehearsal, social skills training, relaxation and biofeedback, as well as elaborated treatment systems, such as Lewinsohn's behavioral therapy of depression (Hoberman & Lewinsohn, 1985), which combine various behavioral components with cognitive and social aspects. Behavioral techniques utilize both overt behavior and covert imagery in achieving behavioral change. They generally involve close monitoring of target behaviors, thoughts, antecedents, and consequences as ways of monitoring progress and of generating clinical information necessary in designing treatment strategies. Cognitive processes form a vital part of many of these behavioral treatments, and many techniques form a link between cognitive and behavioral methods. For example, thought stopping, covert rehearsal, covert sensitization and systematic desensitization deal with specific cognitive processes, such as thoughts and images.

Cognitive therapies also encompass specific techniques as well as broad systems of treatment. Techniques include education, challenging and testing assumptions about the self and the world in various ways, adopting the perspectives of others, role playing, cognitive restructuring, and rational persuasion (c.f. Beck & Emery, 1985, Beck et al., 1979; Hollon & Beck, 1986; Meichenbaum & Jaremko, 1983). Treatment systems include rational-emotive therapy (Ellis, 1962), stress inoculation therapy (Meichenbaum, 1985), and Beck's cognitive therapy for depression (Beck, et al., 1979). Although these systems and techniques share many characteristics, they each have certain features which may render them more or less amenable to cross-cultural use. In common is the view that how a person thinks affects how they feel and function, and that recovery from emotional disorder can be achieved and maintained by correcting erroneous, unproductive, dysfunctional thinking. They differ on how they go about altering cognitions, the degree to which they adhere to a particular philosophy or value system, and the degree to which behavioral assignments are integrated into treatment (Hollon & Beck, 1986). These differences may make them more or less adaptable to persons from different cultures with different value systems. For example, rational-emotive therapy (Ellis, 1962) incorporates a philosophy of life which would appear to clash with values of societies where the needs and

desires of individuals are supposed to be secondary to the collective needs of the family. Attempts to argue against deep-seated value systems would be likely to alienate clients.

As with crisis intervention, several aspects of behavioral and cognitive therapies make them consistent with general recommendations given for therapy with refugees. These characteristics include a targeted approach to symptoms, an active therapist and directive mode of treatment, and often an active intervention in concrete aspects of life. Casas (1976) advocates using behavioral techniques with Mexican-American populations because 1) the techniques have derived from social and experimental psychology; 2) their basic goal is the alleviation of suffering and enhancement of functioning; 3) they usually involve a method of monitoring progress and treatment outcome; 4) they usually involve reeducational efforts to improve functioning as measured by increased skill, independence, and satisfaction; and 5) the practice of the therapy is usually guided by contractual agreements between client and therapist specifying the desired result and the method of intervention (Davison & Stuart, 1975). In general, behavioral therapies are targeted at specific, definable symptoms and behaviors, and use procedures directed against these. The goals are not personality change or reorganization, but are much more focused. For these reasons, the procedures are seen as more culturally neutral and responsive to individual needs than insight-oriented psychotherapy (Casas, 1976). Additional advantages are that behavioral therapies are less language-bound than psychodynamic, cognitive, or even supportive therapies, making them more amenable than other therapies for patients having to use their second language, and that phases of behavioral therapy, such as in vivo exposure, can be carried out by paraprofessional personnel with periodic supervision.

Cognitive and cognitive-behavioral therapies have as a primary focus the alteration of thought patterns, beliefs, and assumptions (Hollon & Beck, 1986). They share the behavioral tradition of experimentation, a problem-oriented focus, an active therapist, and an approach tailored to the specific circumstances of the individual. Most cognitive therapies also include behavioral assignments and a focus on changing patterns of behavior as well. In fact, cognitive therapies which do not include explicit behavioral components have not generally proved as effective as those that do (Emmelkamp, 1986). This has led to some controversy over whether cognitive is truly distinct from behavioral therapy except in terms of the explanatory system (Latimer & Sweet, 1984).

Refugee Psychopathology: Implications for Cognitive-Behavioral Therapy

Refugees suffer primarily from anxiety and depressive disorders (Garcia-Peltoniemi, 1987; Nguyen, 1985; Tung, 1985), although they are also at increased risk for paranoid and psychotic disorders of various kinds. In terms of psychotherapeutic efficacy, cognitive and behavioral therapies have become increasingly accepted as treatments of choice for anxiety and depression.

Behavioral therapy has become a dominant practice in treatment of anxiety disorders, in particular for simple phobias, social phobia, and agoraphobia, for which the efficacy of exposure therapies is well documented (Emmelkamp, 1986). Cognitive treatments such as that designed by Beck et al. (1979) have proven highly effective against unipolar depression (Hollon & Beck, 1986).

Therapists must be concerned with the unique aspects of refugee psychopathology, however. Although it may be noted that the two major classes of disorders that refugees suffer from, i.e., depression and anxiety, are the same two that behavioral and cognitive approaches have greatest efficacy for, meeting DSM-III-R requirements for a disorder gives only a partial understanding of the full condition of the refugee. DSM-III-R was not designed for a population with the extraordinary set of life experiences which many refugees have experienced. Refugees in mental health centers frequently meet full criteria for, or have many symptoms of major depression, adjustment disorder, and post-traumatic stress disorder (Mollica, Wyshak, Coelho, & Lavelle, 1985). In addition, these conditions are often compounded by unresolved grief, profound isolation and alienation, and difficult environmental circumstances (Ben-Porath, 1987a; Nguyen, 1985).

It seems inappropriate to compare this complex of signs and symptoms with the usual unipolar depression treated with cognitive therapy, or the more common phobic anxieties which are treated using behavior therapy. Therefore, the decision as to whether or not to employ any one of these methods needs to be made with great care. Beck and colleagues do not advise use of cognitive therapy with persons who are bipolar depressives or psychotic. In addition, they express concern that the limits of applicability with respect to educational level, "psychological mindedness," and attitude toward psychotherapy have not been defined. On the other hand, indications for cognitive therapy include an unwillingness or reluctance to take medication, and depression which is refractory to medication attempts (Beck et al., 1979). This is an important point with refugees, because although medication is a culturally-sanctioned form of treatment, there are frequently very great difficulties in achieving proper compliance (Kinzie, 1985a, 1985b).

With persons who have been severely traumatized, all therapies are likely to carry some risk. These risks include exacerbating the patient's condition, alienating the patient, and alienating the patient's family, resulting in loss of social support. Even relatively "safe" methods such as supportive listening and gentle probing about a person's traumatic experiences can exacerbate their symptoms and may not lead to later symptom relief (Kinzie et al., 1984). Approaches which attempt to desensitize refugees to situations which remind them of their traumatic experiences must be conducted in the context of a highly supportive, sensitive and trusting relationship. For example, the Denmark Rehabilitation Center for Torture Victims provides restorative dental care to victims of dental torture. The site and tools of the care can be very anxiety- provoking to the

patient. Therefore, the patient is trained in relaxation before treatment, is provided information about the treatment process and about changes in the course of treatment, and is accompanied by supportive staff. These steps help the patient accept dental treatment without further trauma (Genefke & Aalund, 1983).

Cognitive and behavioral strategies should be incorporated into an overall framework which allows for grief counseling, practical life skills training, networking, involvement of family, and medication as necessary. In discussions of cross-cultural and minority psychotherapy, a common theme is that an eclectic approach is generally necessary to meet the varied needs of the client (Acosta et al., 1982). This is especially true when dealing with refugees. Many refugees will only come to a mental health center when all other alternatives for help have been exhausted, and when they are in a serious acute or chronic state (although this might not be the case if services were better integrated in the community). When depression and grief are present, the potential for suicide should always be kept in mind, and psychiatric assessment and treatment employed whenever indicated. The literature has made it clear that providing medications is a culturally-appropriate and accepted method of treatment, and can help in establishing trust and rapport with the refugee patient (Kinzie, 1985a; Kinzie et al., 1980).

Cross-cultural Application of Cognitive and Behavioral Techniques

Although there have not been reports of therapists using cognitive and behavioral therapy specifically with refugees, there is a fairly extensive literature about its use in other cultural settings, including some which are similar to those from which we have received refugees.

Buddhist cultures

The majority of refugees in the United States have come from Southeast Asia, where Buddhist influence is generally very strong. Interestingly, behavioral and cognitive therapies bear some striking similarities to many early Buddhist teachings. De Silva (1984, 1985) and Mikulas (1978, 1981) discussed very direct parallels between Buddhist teachings and the techniques of cognitive and behavioral therapies. For example, behavioral techniques such as modeling, stimulus control, reciprocal inhibition, social skills training, and use of specific rewards all have parallels in the early Buddhist writings (De Silva, 1984). Techniques of dealing with intrusive thoughts such as thought stopping, thought switching, distraction, and considering negative effects of thoughts were also elaborated (De Silva, 1985). De Silva (1985) also noted examples of treatments given to persons with severe grief reactions which were highly consistent with today's method of cognitive change through performing actions which disconfirm pathological beliefs, such as belief in the impending return of a dead loved one. De Silva believes the similarity of modern cognitive and behavioral approaches to Buddhist approaches, especially when recognized by the practitioner, helps make these approaches very acceptable to cultures with Buddhist

traditions. Accounts by Mikulas (1983) of the current status of behavior therapy in Thailand indicate that it is much better received than other Western therapies such as supportive verbal psychotherapy and encounter groups, which are more alien to the culture. The fundamentally pan-cultural nature of behavioral therapy allows it to be readily adapted to the new cultural contexts.

Hispanic Cultures

The second largest group of refugees in the United States includes Spanish-speaking persons from Cuba and other Central and South American countries. The use of behavioral individual and group therapy with persons of Hispanic descent (not refugees) has been reported and advocated by various authors (Arce & Torres-Matrullo, 1982; Casas, 1976; Comas-Diaz, 1981, 1985; Herrera & Sanchez, 1976; Stumphauzer & Davis, 1983a). Arce and Torres-Matrullo (1982) describe the treatment of a Puerto Rican woman using cognitive restructuring techniques, and group treatment of Puerto Ricans using interpersonal problem solving, assertiveness training, and cognitive restructuring. They state that Hispanic patients expect treatment to "be characterized by (1) immediate symptom relief, (2) guidance and advice giving, (3) a concrete focus, and (4) a problem-centered approach" (p. 232). They considered cognitive-behavioral therapy to be particularly applicable due to its lack of emphasis upon insight or emotional release given, and the expectations brought to therapy by their patients. Comas-Diaz (1981, 1985) also utilized cognitive and behavioral treatments of depression with Puerto Rican women in a group format, and found both approaches relevant to and consistent with cultural expectations of therapy. In addition, Comas-Diaz (1985) analyzed the content themes of the group sessions and found them fully reflective of culturally-based concerns, approaches to life, and attitudes toward family and health. Stumphauzer and Davis (1983a) trained Mexican-American mental health personnel in behavioral techniques, and reported that trainees found the techniques highly useful and appropriate for their clients. These studies illustrate the flexibility of the approaches, which take their methods from western science, but their content from the cultural and individual characteristics of the person in treatment.

Reports from within Latin America itself indicate that, with a few exceptions, behaviorism is rapidly gaining ground as an effective and accepted treatment approach (Ardila, 1982; De Rosemberg & Delgado, 1985). Again the flexibility of the approach and its adaptability to different cultures and settings makes it highly useful.

Other cultural Settings

Reports on the use of behavioral and cognitive approaches are also available from India, Japan, and Ghana. Singh and Oberhummer (1980) report the successful use of behavioral therapy with a phobic woman within the context of Karma Yoga in the Hindu culture of India. The treatment utilized a combination of in vivo flooding with participant modeling, assertiveness

training, and education about her problems. The authors note that the action oriented approach of behaviorism is consistent with Karma Yoga, which teaches that change in behavior will precede complementary cognitive and affective change. Danquah (1982) reports the growing success and acceptance of behavioral therapy in Ghana, West Africa. He found behavioral treatments effective for a variety of neurotic, anxious and depressive disorders where pharmacotherapy, traditional healers, and psychoanalytic approaches have failed. Stumphauzer and Davis (1983b) have reported the successful training of Asian-American therapists in behavioral techniques. As in their previously cited work with Mexican Americans, the techniques were reported highly useful and applicable to the population. In contrast, Yamagami, Okuma, Morinaga, and Nakao (1982) reported difficulties in getting behavioral therapy accepted in Japan, possibly because a reductionist approach is less accepted, at least by the mental health professionals, than more holistic approaches. However, even the Japanese treatment of Morita therapy has many features of cognitive therapy, although these are presented somewhat differently than in Western cognitive therapy (Ishiyama, 1986).

Although the studies cited in this section report the successful use of behavioral therapies in a variety of cultures, they tend not to make specific recommendations with respect to adapting instructions and techniques to persons from other cultures. Instead, several common themes emerge from the case studies and their discussions of therapeutic approaches. First, behavioral analyses were conducted within the cultural context, with the meaning of significant events, disabilities, and social disruptions considered accordingly. Second, challenges to existing dysfunctional belief systems were handled delicately, frequently enlisting cooperative family members. In one report (Danquah, 1982), a patient who believed she would experience dire consequences if someone sneezed on her right side had this belief challenged first by a behavioral explanation of the phobia offered by the therapist, then by family members who were instructed to sneeze on her right side in the mornings. Progressive treatment erased the phobia. Although this example is quite similar to how treatment would proceed in an American case, the situation was unique in that the therapist was challenging what the woman had been told by a traditional healer. Critical points in the treatment were the woman's willingness to carefully subject the contradictory predictions of the healer and the therapist to a test, and the family's willingness to cooperate. A third theme, particularly brought out by Arce and Torres-Matrullo (1982) involves dealing with dysfunctional, global beliefs and assumptions after successfully applying behavioral treatments and establishing a trusting therapeutic relationship. In their case of the depressed Puerto Rican mother, an educational approach first helped the patient understand the connection between her distressing symptoms and degrading, destructive circumstances in her life. After focusing on making successful behavioral changes to relieve the circumstances, her global, dysfunctional assumptions

and cognitions began to become more clear, with the help of the therapist. At this point, the treatment moved to an effective cognitive-behavioral approaches, which also included assertiveness training.

Models for Applying Cognitive and Behavioral Therapies with Refugees with Specific Disorders

Bearing in mind that disorders among refugees are seldom "pure" cases, the following discussion will focus on strategies of intervention for specific disorders, review cross-cultural work with the therapy when it exists, and make some comments on how the therapy might be adapted for different refugee groups. For a discussion of possible preventive interventions for the following disorders and several others, see Williams (1987). In her paper, Williams (1987) also emphasizes the potential utility of crisis intervention and cognitive-behavioral techniques.

Depression

Beck's cognitive therapy of depression (Beck et al., 1979; Sacco & Beck, 1985) is a method with promise in mental health treatment of refugees. Beck's technique is highly adaptive in the sense that the specific target cognitions and their situational context are drawn from the patient's life. In addition, the method of collaborative empiricism demands that the patient be involved in generating tests and possible disconfirmations of depressogenic thoughts. In the following paragraphs, the context of Beck's model will be used to illustrate points which might emerge in any application of cognitive or behavioral therapy.

Difficulties may emerge in applying cognitive therapy of depression to persons from some refugee groups. The first problem involves presentation of the rationale, an issue which gets to the heart of the cross-cultural application and acceptability of the treatment. Depression is frequently manifested somatically, rather than as an emotional or mental problem, with various pains and aches, appetite and sleep disturbance, and exhaustion the focus of complaints (Kinzie, 1985a; E. H. Lin, Ihle & Tazuma, 1985; Nguyen, 1982; Tung, 1985). If the patient believes the problem is physical, it would be difficult to present a cognitive rationale for complaints. In contrast, Beck et al. (1979) attribute depression to cognitive distortions which revolve around patients' distorted, negative view of themselves, their future, and the world. Patients see themselves as "defective, inadequate, diseased, or deprived (p. 11)." Various rigid, global, and negatively toned schemata influence how external stimuli are interpreted, and these errors and distortions in processing information promote and maintain the depression (Sacco & Beck, 1985). The challenge is to develop the confidence of the patient to the point where alternative explanations can be offered without arousing suspicion or alienation.

Presenting the rationale is an important aspect of treatment, because the knowledgeable collaboration of the patient is crucial in generating and challenging dysfunctional thoughts, and

because a long-term goal is to help the patient recognize automatic and distorted thoughts when they occur in the future, and to learn to deal with them. Therefore, an educational component will be crucial in the adaptation and introduction of cognitive therapy. This is especially true because the affective and cognitive aspects of depression may not be the primary complaint of the refugee patient. Attempts at addressing affect and cognition without first responding to the primary somatic complaints are highly likely to alienate the patient and create an atmosphere of mistrust. This might involve a psychiatric referral and appropriate medication, as well as addressing certain very practical problems in the patients life through direct intervention and/or assistance in problem solving. One potentially productive way of introducing the rationale would be to refer to the high level of stress and trauma endured by the patient, and to discuss the sort of impact that this might be expected to have on any person's life.

Even though the initial symptom presentation may be somatic, studies have shown that refugees will acknowledge affective distress when asked, and will complain of problems they are having in their daily lives (Kinzie, 1985b; K. M. Lin, Tazuma, & Masuda, 1979; Mollica, Wyshak, de Marneffe, Khoun, & Lavelle, 1987). As noted earlier, working with these concrete problems can serve as an entre to other issues, as well as being therapeutic in its own right. Prescribing activities which will help the person get motivated and provide positive feedback can lead to discussions of world views and dysfunctional thinking which contribute to the depression. This may be an advisable course whether or not the refugee receives medication. Once a course of medication and/or other treatments intended to address the somatic and daily living complaints has begun, the introduction of the method and goals of cognitive therapy might begin.

In general, the notion that thought-affect-body are tightly interwoven should not seem alien to refugees from countries where the Western mind-body dualism is not followed. The thought-affect-somatic interaction which underlies cognitive therapy is an holistic concept which may be emphasized productively with persons from these cultures. Although basic explanatory mechanisms and concepts of causative sequences may be different, the fact that thinking affects feeling and body and vice-versa is central and should be comprehensible. Another positive component is the fact that the tenants of cognitive theory are demonstrated through daily living rather than by persuasion. No belief system need be introduced or controverted in the presentation of the concepts. Instead, all that is required is for a patient to be open to the possibility that the therapist is right, and willing to undertake some experiments. As an aside, if an interpreter is being used, he or she should first be trained in the concepts which are to be explained.

Beck's cognitive therapy approach also utilizes the techniques of bibliotherapy and behavior recording (Beck et al., 1979). This may represent a problem because many refugees are illiterate or marginally literate in English, and many are not literate in their native language. The use of a

small cassette tape recorder to record behaviors and thoughts may be one way to circumvent this problem. Monitoring might also be assisted by concerned family members. In addition, patient self-monitoring on a visual analog affect and pain scale might be possible as well as highly useful. Clinics which serve large refugee populations may find it useful to translate portions or all of the "Coping with Depression" (Beck & Greenburg, 1974) booklet, although translation is a difficult and time-consuming task. This could serve non-refugee minorities as well; the large number of native-born citizens and immigrants with Spanish as their native tongue would make the production of such a translation broadly useful.

An important behavioral approach to depression is described by Hoberman and Lewinsohn (1985), which has evolved from Lewinsohn's initial theory of depression as a state which results as a function of low rates of positive reinforcement and/or high rates of aversive experience. Clearly both of these may be present in the recent life of a refugee. Behavioral strategies consist of restoring an adequate schedule of positive reinforcement in the person's life, thereby reducing dysphoria and depression. Commonly, alterations are made in the frequency, quality, and range of the patient's activities and social interactions.

Many specific aspects of treatment are similar to what happens in cognitive therapy. After an extensive assessment of the person's life in terms of stressors, support systems, and sources of reinforcement (including psychiatric assessment and provision of medication of necessary), the therapist and patient attempt to clarify and redefine the problem -- a cognitive task. Similar to the Beck et al. (1979) approach, there is an emphasis on monitoring mood and activities, and on progressive goal attainment. Unlike cognitive therapy, however, there is a much less explicit attempt to identify and monitor dysfunctional thoughts and assumptions, although patients are taught to discriminate between positive and negative thoughts, and thought stopping and other techniques are taught to deal with them. The major difference from cognitive therapy would appear to be a lack of focus on empirical refutation of erroneous beliefs, although such beliefs are challenged as they emerge. An important difference with respect to cross-cultural adaptation is that no explanatory system is necessary beyond the obvious one that problems contribute to dysphoria. The focus is then to redefine the problem so that better solutions can be found. This constitutes an advantage over providing a linguistically complex theoretical framework to patients who may be illiterate in their own language and who are not psychologically sophisticated. It would therefore appear that the behavioral model may be somewhat more easily applied than cognitive therapy. However, Hollon (1987) considers specific cognitive change of the sort which occurs in Beck's treatment crucial to achieving long-term recovery, and would therefore consider purely behavioral approaches less desirable. Empirical data are not available to answer this question absolutely, especially with refugees. In any case, behavioral treatment may serve as the beginning point for

cognitive therapy, with a cognitive focus developed as the relationship and communication level improve.

Post-traumatic stress disorder (PTSD)

Our knowledge about psychotherapy for PTSD is still largely in the descriptive phase, with a variety of suggestions offered for treatment (Figley, 1985; Horowitz, 1986; Scrignar, 1984). A number of refugees diagnosed as depressed may also have associated PTSD. Current refugee treatment for PTSD commonly relies upon medications prescribed according to dominant symptomatology, together with supportive counseling (Kinzie, 1985b; Kinzie at al., 1984; Mollica et al., 1985). Few detailed accounts of PTSD treatment in refugees are available in the literature, and none of these has a cognitive or behavioral focus. Instead, attempts have been made at recovering and disclosing memories of the trauma, and coming to terms with the experience such that it is no longer disabling. In some sense, "coming to terms" with or "integrating" the experience could be considered a cognitive task, but the cognitive process and method is not defined. Similarly, Somnier and Genefke (1986) consider the initial phase of their psychotherapy with tortured refugees in Denmark to be cognitive, the purpose being to recreate the experience cognitively and to provide a cognitive context for the experience (the torturer had an explicit goal of destroying the victim's personality). They also attempt to have victims recognize that their responses were inevitable, and that they should not feel guilty or ashamed of their behavior during or after their torture. Similar needs for cognitive restructuring are reported by Danieli (1985) for holocaust survivors. Again, however, the processes and methods by which this occurs are not well defined.

The process of recovering memories seems to be a risky one, with no guarantee of curative effect, and possibly some danger of exacerbating the symptoms (Kinzie et al., 1984). However, Mollica (in press) reported that accessing the trauma story gently and over a long period of time, while providing the refugee with a supportive context, was quite effective and perhaps the only way to achieve long-term mental health gains. Cienfuegos and Monelli (1983) have reported symptomatic relief of stress response symptoms among victims of torture in Chile by having them provide extensive tape-recorded testimony about their abuse. Initially, such testimony was gathered for legal reasons, but after noting a therapeutic effect, the method was used as part of a treatment program to help the victim integrate the experiences into their lives. Workers in the Denmark Center also believe that a complete and thorough recollection of the trauma experience is necessary for recovery (Somnier & Genefke, 1986). Frederick (1987) also believes that specific memories must be recovered for treatment to be effective. Clearly, research needs to be conducted to determine more precisely when the memories should be pursued, in what detail, under what circumstances, and with whom.

Behavioral treatment of post-traumatic stress symptoms among veterans has been described by Keane, Fairbank, Caddell, Zimmering, and Bender (1985). Their approach has included imaginal flooding, and stress management utilizing relaxation and cognitive restructuring procedures. Imaginal flooding was found useful in reducing anxiety related to nightmares and flashbacks of traumatic war experiences, and decreasing the frequency of these flashbacks and nightmares (Keane & Kaloupek, 1982). Similar treatments have been effective in reducing driving phobia in patients who experienced traumatic automobile accidents (Kuch, Swinson, & Kirby, 1985). Bowen and Lambert (1986) reported the effectiveness of systematic desensitization in reducing excessive arousal in veterans provided cues related to a war-related traumatic experience. Other applications of behavioral therapy of PTSD have been reviewed by Scurfield (1985). These have included stress management, systematic desensitization, thought stopping, cognitive restructuring, and bibliotherapy. Scrignar (1984) also advocates behavioral approaches to targeted anxiety-provoking aspects of PTSD. These approaches seem useful when circumscribed anxiety-provoking stimuli and events can be identified.

An interesting group model for treatment of traumatic stress symptoms has been described by Flannery (1987). His groups employ a stress management approach to increase patient's sense of control over their lives and reduce the use of numbing and denial defensive mechanisms. The treatment incorporates reduction of dietary stimulants, relaxation, exercise, and a stress inoculation process. The stress inoculation portion emphasizes development of useful behavioral and cognitive coping strategies. While these patients did not necessarily meet DSM-III criteria for PTSD, they had experienced traumas from rape, incest, domestic violence, and other family problems. The data from the program are still preliminary, however, there appeared to be an enhancement in the patients' sense of control and efficacy in their lives, together with a greater willingness to deal actively with their traumatic experiences.

The relevance of these rather preliminary findings to work with traumatized refugees is not fully clear. It appears that, if phobic anxieties have developed as a result of certain experiences, then techniques such as exposure and desensitization might be advisable to reduce the impairment and discomfort which results. In addition, relaxation techniques and cognitive coping processes (in conjunction with medication) might be employed to treat chronic pain and insomnia. Flooding techniques should only be employed with great caution, and probably should not be attempted with more highly traumatized refugees until more is known about the effects of such treatments on persons who have undergone extensive and prolonged trauma. If there is one point of agreement in the field, it is that the trauma story must be pursued slowly and carefully, taking the lead of the patient in terms of how far to explore at any given time (Parson, 1985).

Interpersonal dynamics will probably affect the likelihood of recovering the trauma story. For example, a history of sexual abuse may only be divulged to same-sex therapists and interpreters by refugees. The importance of the therapeutic relationship, the interpersonal dynamics with family and friends, and the opportunity for abreaction must be stressed in treatment of PTSD. Cognitive-behavioral strategies will probably account for only a portion of the total treatment package.

Grief

In general, cognitive and behavioral therapy are not intended as treatments for normal or abnormal grief, and possibly an interpersonal approach (Rounsaville, Klerman, Weissman, & Chevron, 1985) would be more appropriate, with supportive therapy and opportunity for abreaction. However, cognitive and behavioral therapies can be used to address certain dysfunctional thoughts and behaviors, as well as to help deal with anxieties which resulted from the loss (Beck et al., 1979).

Behavioral analyses of grief have been conducted (Brasted and Callahan, 1984), and behavioral approaches to therapy have been used, such as prescribing rituals, and circumscribed time periods in which to mourn (Janson, 1985). These are applied in conjunction with other techniques, more interpersonal and insightful in nature, which assist in accepting the loss and building new social support systems.

Other Anxiety-Related Symptoms and Disorders

Refugees have consistently been reported to have high levels of anxiety-related symptoms (Garcia-Peltoniemi, 1987; Nguyen, 1985). These symptoms consist of restlessness, inner tension, feelings of worry and insecurity about the future, panicky feelings, fear, headaches, insomnia, nightmares and difficulty concentrating. These problems are often associated with concurrent depression and post-traumatic stress syndromes. The anxiety symptoms therefore are based on certain tangible problems of adjustment and adaptation, as well being the sequelae of particularly distressing life events.

Behavioral methods commonly employed in treatment for phobias and other situationally-triggered anxiety include systematic desensitization, imaginal and in vivo flooding, graded exposure therapy, and participant modeling. These methods should be adaptable for use with refugees with little modification. Perhaps the main caution is that an adequate behavioral analysis of the phobia be conducted, with attention given to any special cultural significance and interpretation of the problem. In addition, if the anxiety-provoking stimulus relates to a traumatic event, the same cautions should be followed concerning flooding and other attempts to dealing with traumatic events that were discussed with regard to PTSD.

The cognitive perspective on anxiety, and a detailed account of cognitive treatment practices is presented by Beck and Emery (1985). The treatment shares many themes and techniques with cognitive therapy of depression discussed earlier, but with a focus on anxiety-producing thoughts, and a greater focus on treating catastrophic and anxiety-laden images and the stimuli which evoke them. There is less outcome data on cognitive therapy of anxiety than of depression (Beck and Emery, 1985; Hollon & Beck, 1986), but in general it appears that some form of behavioral treatment such as in vivo exposure is vital for achieving best results (Emmelkamp, 1986). In fact, the cognitive treatment as described by Beck and Emery (1985) includes such behavioral components.

Another potentially useful model for treating anxiety and stress-related symptoms is the Stress Inoculation Training program developed by Meichenbaum (1985). This cognitive-behavioral treatment model has application to a wide variety of persons who are experiencing difficulty in coping with stress, both past and present, in their everyday lives. The difficulties can be manifested by symptoms of anxiety, depression, or feelings of loss of control and fear of "going crazy" at times of stress. The stressors can range from everyday problems in dealing with work or school to traumatic stress resulting from terrorization (Ayalon, 1983; Meichenbaum, 1985; Veronen & Kilpatrick, 1983).

Stress Inoculation Training is a multifaceted, flexible treatment system in which specific aspects of an individual's treatment are arrived at through application of the training principles, collaboration with the patient, and experimentation. Meichenbaum (1985) notes that the sensitivity to individual needs, the flexibility of the approach, and the use of collaboration and experimentation allows cultural factors to be taken into consideration and to guide treatment. Stress Inoculation Training focuses on developing and enhancing coping mechanisms which are consistent with one's personal and cultural beliefs. Unfortunately there are few data on the cross-cultural application of Stress Inoculation Training.

Stress Inoculation Training occurs in three phases: conceptualization, skills acquisition and rehearsal, and application and follow-through. Meichenbaum (1985) makes it clear that the effectiveness of Stress Inoculation Training requires that all phases be carried out. In the conceptualization phase, the patient's problems are drawn out in interviews and clarified. Particular attention is given to those times when a person feels overly stressed or when symptoms are exacerbated, and thoughts and feelings associated with the events are solicited. Self-monitoring exercises are used between sessions wherein the patient records thoughts and feelings. At the end of the first phase, the clinician presents and discusses a reconceptualization of the patient's problem based upon cognitive-behavioral concepts and clinical experience.

In the skills acquisition phase the patient is taught a variety of cognitive and behavioral coping skills, many of them based upon Beck's work on cognitive therapy of depression. For persons who have been through stressful experiences these are primarily palliative, and include relaxation, cognitive restructuring, searching for meaning, diverting attention, learning coping self-statements, denial, and expression of affect. Specific social, parenting, and problem solving skills are taught which are tailored to the individual, the circumstances, and the culture. These techniques are then rehearsed with the therapist and in imaginal situations. The third phase involves actual application of the techniques in life situations, with follow-up and encouragement from the therapist.

As can be seen, Stress Inoculation Training provides much leeway for a therapist to consider and modify treatment according to cultural values, attitude, and social systems. Certain aspects may still prove problematic for some refugees, however. As with treatment of depression, the rationale may be initially difficult to explain, especially if it runs counter to traditional expectations. In addition, the educational aspect might be difficult to accomplish through an interpreter, especially if the interpreter is not thoroughly familiar with the treatment concepts and procedures. However, given sufficient time to build the therapeutic relationship and to establish oneself as competent and concerned, and sensitive to the patient's world view and social context, the conceptualization should be able to proceed on a give-and-take basis. Self-monitoring and recording of thoughts, images, and feelings would be difficult for illiterate persons, although this may be circumvented through use of a tape recorder. As in other forms of cognitive therapy, the patient doesn't need to accept at face value what the therapist says, but rather needs to be willing to cooperate within the context of the therapy to provide clinical material, and to collaborate in developing and attempting coping strategies and tests of personal assumptions and belief systems.

INTERPERSONAL APPROACHES TO PSYCHOTHERAPY WITH REFUGEES

Interpersonal Conflicts

Emotional problems experienced by refugees can involve difficulties with interpersonal relationships including intergenerational conflict (Stein, 1986), marital conflict (Nguyen, 1985), difficulties in relating to one's own ethnic community (Westermeyer, 1986), or difficulties with the community in the host country (Westermeyer, Vang, & Neider, 1983a). These various psychosocial stressors and their effects on refugee adjustment have been reviewed by Ben-Porath (1987b). Problems may be manifested in an overt manner, such as through separation or divorce (Westermeyer, Vang, & Lyfong, 1983), physical abuse (Kinzie, 1986), clinical depression (K. M. Lin et al., 1982), psychosomatic complaints (E. H. B. Lin, Carter, & Kleinman, 1985), or substance abuse (K. M. Lin, 1986). In addition, there may be other interpersonal problems, such

as frequent arguments, avoidance of friends or relatives, or poor educational or occupational performance.

Therapy for Interpersonal Difficulties

This section presents several psychotherapies grouped within three broad treatment modalities: individual, marital, and family, which address interpersonal conflict. Issues which mental health professionals should be aware of when using these therapies with refugee clients are also discussed.

Individual Interpersonal Psychotherapies

Sullivan was one of the earliest psychiatrists to emphasize the importance of interpersonal relationships in psychotherapy. He maintained that psychiatric study should focus on the social processes between people rather than narrowly on the minds or society. Sullivan and his colleagues developed a theory which connects psychiatric disorders to interpersonal relations for both the developing child within the family and for the adult within the wider transactions of his or her life (Sullivan, 1956). Consequently, he shifted his approach from one of intrapsychic to interpersonal processes, and examined the patient's current interpersonal relations. Moreover, his interpersonal approach influenced the development of family therapy. Prior to Sullivan, Adolf Meyer recognized the importance of the patient's current life situation and social relationships, and viewed mental illness as an individual's way of coping with the changing environment (Meyer, 1957). However, Meyer did not specify particular features within one's environment that related to the emergence of mental illness. Other neo-Freudians, such as Frieda Fromm-Reichmann, Eric Fromme, and Karen Horney contributed to the development of the interpersonal approach to treatment (Klerman, 1979).

Many psychotherapies which focus on relationship issues have since been developed (Anchin & Kiesler, 1982). For example, in interactional individual therapy (Cashdan, 1982), the therapist guides the patient in learning more productive ways of relating to other people and replacing prior maladaptive strategies. Another approach, brief interactional psychotherapy (Coyne & Segal, 1982) focuses upon teaching the client to deal more effectively with life transitions, such as marriage or the birth of a child. Interpersonal Psychotherapy may be particularly appropriate to those clients from "traditional" cultures, such as the cultures of Southeast Asia, because of the importance these groups place on maintaining harmony and interdependence among family and friends. In contrast, therapies which emphasize individual autonomy and independent growth, values which are prominent in Western societies, may prove to be ineffective or alien to the refugee populations due to a lack of convergence on common values. The following section presents interpersonally oriented therapies in which the individual alone is seen by the therapist.

Interpersonal Psychotherapy

Interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) was developed out of a recognition that depression occurs in the context of interpersonal relationships. Interpersonal psychotherapy is aimed at improving the depressed individual's interpersonal functioning and social adjustment by focusing on current interpersonal functioning. Past behaviors are examined only as a means of gaining understanding into the patterns of present relationships. The difficulties faced by the clients are not regarded as a reflection of an intrapsychic conflict, but are conceptualized in terms of interpersonal relationships. When cognitive distortions are uncovered, the interpersonal therapist makes no attempt to work on them systematically, as occurs in the cognitive-behavioral approach. Rather, these distortions are examined in terms of the effect they may have on interpersonal relationships. The interpersonal therapist typically addresses problems from four major areas: 1) grief, 2) interpersonal disputes with family members, spouse, children, friends, or co-workers, 3) role transitions, and 4) interpersonal deficits, such as loneliness and social isolation. Interpersonal psychotherapy is usually time-limited but can be expanded for use in marital therapy (Klerman et al., 1984) when more sessions are required.

A high percentage of refugees are depressed, consequently Interpersonal Psychotherapy may be useful with these individuals. However, the therapist must first understand the scope of the stressors and obstacles the refugee client faces. One major point a therapist needs to remember is that all refugees have experienced significant losses. They have lost their native country and cannot return home. Many have lost their loved ones, either through death or separation. Many more have lost personal belongings and property. Grieving must then become an integral part of therapy.

Conflicts between family members can arise from differential rates of acculturation, leading to different values and levels of language skills between generations. In addition, stress related to their migration and resettlement can often cause further disruption in the family. Role transitions are prominent in the refugee family. Not many refugees come to their new country with transferable occupational skills (K.M. Lin, 1986). Unemployment and underemployment can add significant stress to the refugee family. Indeed, Hmong refugees on welfare reported more symptoms of hostility than employed ethnic peers (Westermeyer, Vang, & Neider, 1983b).

Interpersonal difficulties commonly hamper the refugee adjustment. A supportive therapist, using the interpersonal approach may help the client develop more effective strategies for dealing with current interpersonal problems. Such a pragmatic approach is likely to meet the expectations of refugees who prefer to have action-oriented solutions to their interpersonal problems, rather than to merely gain "insight" into their difficulties.

Supportive-expressive psychoanalytically oriented psychotherapy

Supportive-expressive psychoanalytically oriented psychotherapy (Luborsky, 1984) was developed to help individuals deal with their intrapsychic conflicts through the examination of a client's interpersonal problems. Supportive-expressive therapy has its origins in psychoanalysis (Freud, 1958). Two distinct differences between classical psychoanalysis and supportive-expressive therapy are the latter's shortened length of therapy and its adaptability to a relatively broad range of patients. Although supportive-expressive therapy is typically an individually oriented approach, it is open to having family members or other significant persons join the sessions.

In treatment, past and current relationships are examined to identify pervasive relationship patterns. Luborsky (1984) has referred to this pervasive pattern as a "core conflict relationship theme (CCRT)". Because of the pervasive influence of intrapsychic conflicts, the client typically repeats his or her core conflictual relationship theme with the therapist. These themes are worked through in therapy, leading the client to think about relationship problems in a different light and, therefore, find a more adaptive way of interacting.

In adapting this type of therapy approach to refugees, it is important to remember that refugee clients regard the therapist as an authority figure who should be treated with deference and respect. With such a stance on the part of the client, it is difficult for pervasive relationship patterns to emerge in the therapist-client relationship. Initially, only a circumscribed set of socially appropriate behaviors will be presented in sessions and a limited set of topics will be discussed. The therapist must take time and care to establish rapport with the refugee client before the client feels comfortable enough to confide in the therapist. Unless the therapist is careful to set the appropriate conditions during sessions, the pervasive relationship pattern of the client will not be manifested during treatment. Rather, the client may terminate treatment prematurely. In addition, the refugee may feel that the discussion of relationships from the past is irrelevant, particularly when the difficulties are current. Time should be taken to emphasize the importance and relevance of such discussions.

Lee (1982) argues that an empathic, passive, and non-directive approach tends to confuse and alienate Asian clients. This may also be the case for clients from other cultures. A directive, active, and structured style may be more helpful because this style is more congruent with the expectations of such clients. The therapist must convey authority and expertise and understand that the therapeutic relationship is hierarchical and not egalitarian. A limited personal disclosure is sometimes helpful in establishing better rapport, particularly when the client inquires. The client will be far more comfortable in disclosing personal information relevant to the treatment under such

conditions. However, the client will likely continue to depend on the therapist to provide structure within the interview.

The therapist must be aware of the difficulties in adjustment which refugees experience and be cautious about drawing quick conclusions about apparent core conflictual relationship themes. A relationship theme which may emerge and appear to reflect a pervasive pattern is one of interpersonal sensitivity and suspiciousness. Paranoid disorders are more common among refugees than among native born (Kino, 1951; Prange, 1959; Garcia-Peltoniemi, 1987). Paranoid thinking often involves delusions of their food being poisoned or of being followed or talked about (Stein, 1986). This suspiciousness may be seen as a pervasive interpersonal pattern; conversely, it may be directly related to adjustment and migration rather than to core conflictual relationship themes.

Another feature of refugee behavior which may be seen is a perception that they are owed something by others (Stein, 1986). Some refugees expect to be compensated for the suffering they have experienced. Since their persecutors are not available, they turn their demands to the helping government and/or agency. These demands are not always granted either by the agency or the case worker. This may result in feelings of bitterness and suspiciousness on the part of the refugee. Conversely, the aid that they do receive may be perceived as a way of humiliating and subjugating them rather than as a positive offer of help.

A major component of the supportive-expressive approach is providing support to the client. The supportive element of supportive-expressive therapy is likely to be invaluable to refugees who often feel alienated and misunderstood. In the past, emotional support for the refugee was offered primarily within the extended family. However, with the dispersion of family and with other family members under considerable stress themselves, support is not easily obtained from this traditional source. In his work with Southeast Asian refugees, Kinzie (1986) finds supportive psychotherapy to be useful. Kinzie emphasizes the importance of developing an ongoing, personal, and comfortable relationship with the refugee clients. Giving appropriate information, feedback and certain amount of independence in the therapeutic relationship is important. In addition, communicating in genuine and calm manner, with appropriate display of full range of affect, and a constructive use of humor may be extremely useful.

Marital Therapies

Applying Marital Therapy to Refugees

Marital conflicts are observed frequently in the refugee population (K.M. Lin., 1986). Couples face tension in their relationship because of various stresses of exodus and resettlement (Ben-Porath, 1987b). When an individual is under stress, one's own spouse is a convenient person on which to displace anger. Also, differences in sex roles between the old culture and the

new can create confusion and problems. It may be that the extended family, which functioned as a buffer and protector for married couples, prior to migration, is no longer capable of fulfilling those functions. For example, in Vietnamese families where the extended family is broken up, increased incidents of marital conflict, including physical violence and divorce, have been observed (K.M. Lin, Masuda, & Tazuma, 1982).

There are many issues that are relevant to both marital and family therapies when applied to refugees. Only those issues which pertain to marital therapies are presented in this section. Refugee couples may have already turned to their family for support and guidance before deciding to consult a mental health professional. Once the couple has decided to seek professional help, it may still be difficult for them to disclose intimate information directly to the therapist. Sensitive and personal topics, which may be viewed as irrelevant to the presenting complaint, will not be spontaneously offered. Sensitive topics are difficult to express even in one's own native language. If an interpreter is present, he or she must be interpersonally sensitive and skilled in conveying the nuances of sensitive material to the therapist.

The presence of different levels of English language skill between the spouses needs to be noted and its implications recognized. In the refugee camps, and also to some extent in the home country, men may have had more opportunities to study English than women (Palmer, 1981). Thus, in therapy a husband may be more fluent in English and more able to express his side of the conflict than his wife. The wife may have to depend more on the interpreter, if present, to report her side of the conflict. Of course, the reverse may be true in some cases. In any case, poor language skills among clients and the necessary dependence on interpreters contribute to loss of information and distortion which leads to inaccurate assessment of the conflict. The therapist must guard against being overly influenced by the spouse who communicates more fluently. Inferences as to the personality or intelligence of the non-communicating spouse needs to be verified by other sources and not inferred merely from clinical impressions during treatment sessions.

It is important for the mental health professional to recognize the cultural structure and characteristics of Southeast Asian families and marriages. Traditionally the husband assumes a dominant role and the wife a submissive one. These roles are embedded in a larger extended family kin system, where there is a clear understanding of sex roles and expected modes of behavior. In some Southeast Asian cultures polygamy is an accepted practice. For example, the Hmong practiced polygamous marriages mostly as the result of levirate, where a younger brother marries the widowed wife of his older brother (Barney, 1979). This practice enabled the older brother's property and children to remain in the family. Polygamy spread widely as the war progressed since many women lost their husbands. These polygamous families do not readily reveal their polygamous relationship once they are in the U.S. A careful and thorough history

taking is essential in getting at this information and their relevance to the conflict. Trial marriage is also a normal practice among the Hmong (Center for Applied Linguistics, 1979). The following section is a discussion of major models of marital therapy which can be used with refugees.

The field of marital therapy emerged in the 1930's and 1940's with a psychoanalytic orientation and a focus on interpersonal relationships (Nichols & Everett, 1985). Although marital therapy was developed earlier and independently of family therapy, the two fields are currently not clearly distinguished and many clinicians view marital therapy to be a subspecialty of family therapy (Gurman & Kniskern, 1979; Jacobson & Gurman, 1986).

Marital therapy deals primarily with relationship and/or interpersonal difficulties between couples. The goal of marital therapy is to help both spouses formulate appropriate expectations for each other and to teach them ways to mutually achieve their goals. Achievement of personal fulfillment at the expense of one's spouse is discouraged. The field of marital therapy contains several different theoretical orientations and therapeutic approaches. Major models include psychoanalytic marital therapy, structural-strategic marital therapy, family systems marital therapy, and social learning approaches to marital therapy (Jacobson & Gurman, 1986). In addition, marital therapies which address specific client populations are emerging. Some available therapies focus treatment on unmarried couples, separated or divorced couples, remarried couples, sexually dysfunctional couples, couples experiencing marital violence, or homosexual couples. Treatment of various psychopathologies, such as schizophrenia, affective disorders, eating disorders, and substance abuse within marital therapy has also been emphasized (Jacobson & Gurman, 1986).

In recent years there has been an increase in the integration of divergent theories and methods of treatment (Feldman, 1985; Pinsof, 1983; Stanton, 1981). For example, the application of communication and problem-solving skills training into strategic/structural marital therapy (Todd, 1986) and the use of paradoxical techniques in psychodynamic marital therapy (Gurman, 1982) have been employed. Nevertheless, each orientation differs in its basic premises and theory. A brief discussion of the major models is presented next.

Models of Marital Therapy

Psychodynamic marital therapy. Psychodynamic marital therapy grew out of psychoanalysis, a treatment approach developed strictly for individual treatment and considered inappropriate for conjoint or concurrent therapy. Early analysts believed that seeing spouses together or separately by the same therapist would interfere with the therapeutic transference between therapist and client. However, therapists with a psychodynamic marital therapy orientation argue that transference relationships which exists between the spouses can be utilized in order to point out individual distortions that result from each person's intrapsychic conflicts. Individual psychodynamics are believed to influence the structure of the marital relationship by

means of unconscious family-of-origin transferences (Dare, 1986). Any unrealistic expectations and unconscious influences and collusive contracts are identified and worked through (Sager, 1976). The treatment goals of psychodynamic marital therapy include interpersonal and intrapsychic restructuring. However, unlike psychoanalysis, psychodynamic marital therapy tends to be brief, and therapists are more active and directive. Techniques to instigate behavioral change, such as communication training, are sometimes used.

Behavioral marital therapy. Behavioral marital therapy (BMT) is one model of treatment which evolved out of two major theoretical orientations, that of learning principles, both classical and operant, and that of social exchange theory (Thibaut & Kelly, 1959). Behavioral marital therapy is highly structured and goal-directed. It focuses on specific behavioral goals, overt behavioral change, and maintenance of newly learned behaviors. Distressed couples typically have difficulty coping effectively with conflict (Gottman, 1979). Therefore, couples are taught communication and problem solving skills in order to experience a more positive exchange. Short-term, time-limited therapy is recommended with this treatment approach (Stuart, 1980).

Behavioral marital therapy appears to be effective in helping couples achieve better relationships (Jacobson & Bussod, 1983; Gurman, Kniskern, & Pinsof, 1986). However, some writers within this orientation are moving away from the traditional behavioral marital therapy model to include cognitive and affective components in treatment. Because of this shift in thinking, the evolved version of behavioral marital therapy may now be called a social learning-cognitive approach to marital therapy (Jacobson & Holtzworth-Munroe, 1986; Stuart, 1980).

Structural-strategic marital therapy. Structural-strategic marital therapy applies the systems theory of both structural and strategic family therapy models to the treatment of couples. Both orientations share common features which can be used in the treatment of couples (Stanton, 1981). However, the possibility and desirability of such an integration in treatment is currently being debated (Fraser, 1984). The therapist tries to establish a healthy and self-sufficient marital system in a goal-oriented and pragmatic manner. This is achieved by active participation on the part of the therapist to encourage any positive skills already possessed by the couple and to develop new and desired skills. Strategic techniques are also devised and implemented to help produce change (Todd, 1984). Stanton (1981) has proposed general guidelines for deciding when to use a structural or a strategic approach. He suggests generally using a structural approach initially and then switching to a strategic approach if the former proves insufficient.

Transactional analysis. Transactional analysis (Berne, 1964, 1972) focuses on transactions, which are defined as units of social intercourse in interpersonal relationships. This therapy is based on a model of personality which consists of three "ego states"- Child, Adult, and Parent. These states roughly correspond to Freud's Id, Ego, and Superego. The Parent is viewed as that

part of an individual's personality which incorporates parental values; the Child is that part which expresses childhood or childlike feelings; and the Adult is that part which processes information in a rational and objective manner.

Berne (1964) characterizes social interactions as "games" because they resemble a series of complementary, self-serving transactions which progress in a predictable manner. Conflict arises when spouses speak to each other using incompatible ego states. The task of the therapist is to analyze the social interaction within couples to help them realize and understand which ego states they use in their communications. The therapist analyzes these "games" and tries to make clients aware of their interaction patterns and the effect which these patterns have on their interpersonal relationships.

In general, many Southeast Asian refugees and those individuals from more traditional cultures are unfamiliar with the psychological concepts used in Western societies. Such concepts as ego-states and abstract descriptions of social interaction patterns sound very "foreign" to them. However, if explained in ways which make use of familiar everyday social interactions, the transactional analysis approach may have an intuitive appeal to the refugees. These individuals are socialized in a society which is organized in a hierarchical rather than an egalitarian social structure. The idea of an individual talking to another as a parent talks to a child may be quite acceptable and appropriate for specific relationships within this structure. If everyone uses psychological transactions which are compatible with the accepted social transactions within a culture, then relationships remain harmonious. Accordingly, the therapist needs to be aware of the hierarchical structure in which refugee clients operate and needs to recognize the dominant role that the husband plays within the marriage. However, the therapist should not be deceived by how these social interactions appear on the surface. The wife may be the more powerful and controlling influence within a marriage even though her public behavior appears deferential.

Sexual dysfunction. Sexual dysfunction is often treated within the context of marital therapy. Historically, sex therapy developed as a separate field from marital therapy (Jacobson & Bussod, 1983). The work of Masters and Johnson (1970) has influenced many researchers in this field and, as a consequence, the strategies used in sex therapy are not as diverse as those used in family or marital therapies. In sex therapy, the therapist functions as an information provider and skills training expert. Therapy generally focuses on dealing with sexual dysfunction and on achieving conditions that will lead to a satisfying sexual life, such as a decrease in performance anxiety.

Although sexual dysfunction surely occurs in some of the Southeast Asian refugee population, it is highly unlikely that refugees will approach a mental health professional specifically for treatment of such problems. Rather, the couple may initially present with other complaints and only subsequent contact may reveal a general dissatisfaction with their marriage and a specific

problem with sexual functioning. Tsui (1985) reports that Asian couples who present specifically for sexual counseling often do so for infertility counseling, counseling for sexual abuse or assault, and sexual dysfunction. However, she notes that recently settled Asian refugees typically do not seek help due to the concept of shame and lack of knowledge and information about human sexuality. A mental health professional who suspects sexual dysfunction must be extremely careful in probing this area. Direct questioning is unlikely to produce informative responses because the topic of sex is extremely private and is not typically discussed with strangers (Tung, 1985). Sufficient rapport needs to be established before such a sensitive topic can be fruitfully broached. Tsui (1985) recommends a behaviorally oriented approach to the treatment of sexual dysfunction such as that forwarded by Annon (1976). This approach focuses only on the sexual dysfunction and is directive and practical. Sensate focus technique (Master & Johnson, 1970) which is a treatment of choice for ejaculatory control, erectile dysfunction, and orgasmic dysfunction for the general population can be inappropriate for recently arrived Asians because this technique emphasizes sexual intimacy and mutual physical stimulation (Tsui, 1985). In cases of infertility, mental health professionals can provide information on medical options, resources available to clients, or can make referrals to a fertility expert.

Marital therapy can be useful for those refugee couples who are experiencing marital conflict and who prefer the marital approach over the family approach. Some couples may not want to involve their whole family because of the nature of the conflict and others may not be able to ask their family to join because of the dispersion of extended families during resettlement. Still other couples may not want their children to hear about the personal side of their marriage. Marital therapy is a desirable modality because its time-limited, pragmatic, and goal-directed approach is congruent with the expectation which Southeast Asian clients have about treatment. Importantly, marital therapy may potentially be applied to the treatment of alcohol-related difficulties and pathological gambling, two problem areas that are on the rise in the Vietnamese communities in the United States (K. M. Lin, 1986; Refugee Assistance Program, 1987).

Family Therapies

Use of Family Therapy with Refugees

Another major area of interpersonal conflict among the refugees is results from family problems. Conflicts can occur for many reasons directly related to their refugee status and stress of resettlement (Ben-Porath, 1987b; K.M. Lin, 1986). There are several factors that mental health professionals need to be aware of when conducting family therapy with refugees clients. One must start with the recognition of heterogeneity of these groups. For example, Southeast Asian refugees include a diverse group of people from Cambodia, Laos, and Vietnam. From Laos alone one can find ethnic groups of Chinese, Hmong, and Mien. Hispanic refugees also differ in their cultural

backgrounds, with refugees from Cuba and other Central American countries. The socioeconomic backgrounds of the refugees are considerably different as well Therefore, a mental health professional can expect to come in contact with a wide range of refugees, with different traditions, cultures, beliefs, values, methods of discipline, etc. However, because there are some similarities among these refugee groups, several general points can be validly made.

For Southeast Asian refugees, family problems are considered to be strictly the affair of the family or clan. Outsiders are typically not privy to information regarding family conflict. Asian cultures in general tend to emphasize the necessity of maintaining a good family reputation. If there are problems, family members are expected to turn to their family for help. Discussing personal family problems with someone outside the family is considered improper. Family problems will therefore not come to the attention of a mental health professional until civil authorities such as the school, police, and courts are involved, or until the family cannot constrain or tolerate the problem behaviors. Families are usually very concerned about their family secrets becoming public. Therefore, the issue of confidentiality must be clearly explained and repeatedly emphasized.

Family therapy sessions with Southeast Asian clients, particularly in the early stages, may be frustrating for the therapist. These clients, who value restraint of feelings and who believe that intimate feelings should be shared only with intimate friends, may have difficulty expressing themselves when in therapy. Embarrassing information, which would put the family in a bad light, may be withheld from the therapist. Parents often refrain from disclosing all relevant information in an effort to protect the image and reputation of the family. Children will refrain from speaking about anything negative, particularly regarding their parents. Tung (1985) reported that more fruitful results can be achieved in therapy if sessions are first held with only the parents present, and then expanded to include the children. When joint sessions are scheduled for the entire family, it should be understood that only one or two specific issues will be discussed. Others state that the therapist should preferably see the whole family for the first session but that the actual therapy can be structured to include the whole family, sub-systems of the family, or significant others, at various stages of the therapy as judged appropriate by the therapist (Kim, 1985; Lee, 1982).

Discussion within therapy is usually limited to the identified patient or to the specific presenting complaint. Explorations into other family issues are perceived as irrelevant and, therefore, are not well received. Once the family members perceive that the presenting complaint has been addressed, the family will likely terminate therapy since they do not see the point in continuing a treatment which discusses seemingly irrelevant issues that the therapist may judge as relevant. Therefore, it is important that the therapist takes time and effort to establish rapport and

gain the confidence of family members before wider issues related to the "family system" are addressed (Lappin & Scott, 1982).

The use of an interpreter further adds to the already complex dynamics of family therapy sessions. The therapist may not be able to observe representative family interactions since the interactions will be contaminated by the interpreter's interaction with the family. Family therapy will not achieve a desired outcome without a strong working relationship between the therapist and the interpreter, a relationship in which the interpreter is aware of the therapist's goals and strategies, and can in turn accurately convey the nuances of the family interaction to the therapist. It is important that the therapist and the translator be able to work well together as cotherapists in treatment.

The importance of the extended family system must be recognized by all therapists. The extended family has traditionally played an important role in Southeast Asian and Hispanic cultures. Its importance has grown even larger since many refugees have lost some or all of their nuclear family during the war or while fleeing their homelands. Moreover, refugees rely heavily on their extended family members to help them assimilate into the larger American society. If the extended family is ignored during therapy, one ignores an important aspect of family experienced by refugees. Southeast Asian refugee patients typically arrive with a family member for individual appointments. One clinic, therefore, decided to initiate a protocol where the refugee patients are routinely interviewed with their families. In this way, the family is incorporated into treatment in a way which facilitates therapy (Yamamoto & Yap, 1984).

Not all members who present together for therapy may be related. Some refugees who were separated from their own families because of the United States government's dispersion policy of resettlement created their own "families" consisting of distant relatives, friends, other refugee strangers, and American "advocates" (Timberlake & Cook, 1984). The loss of family members from either death or separation is often an issue which needs to be addressed before treatment progress is made.

Most family therapists are active and directive in their approach. This directive style is often preferred by refugees who expect therapists to assume an authoritative role. However, an overly confronting and challenging therapeutic style may cause distress and confusion due to feelings of disgrace that it may elicit in some refugee clients.

Overall, family therapy can be useful in helping refugees deal with interpersonal conflicts within their families. Because of the traditional emphasis on the family and on the importance of family balance, cohesiveness, and harmony, family therapy with its goal of improving the functioning of the family as a unit, will likely appeal to those refugees from traditional cultures.

The following section presents various models of family therapy which can be effectively used with refugee clients.

Family therapy developed out of research conducted in the 1950's on communication processes in families of schizophrenics (Bateson, Jackson, Haley, & Weakland, 1956; Bowen, 1978; Wynne, Rychoff, Day, & Hirsch, 1958). An important concept in family therapy is that the symptoms displayed by an "identified patient" can be thought of as reflecting the pattern of disturbance in the overall family (Haley, 1963). Therefore, it is not sufficient to only treat the identified patient, but rather the whole family needs to be treated. The therapist thus focuses attention on the disturbed system rather than solely on the disturbed individual.

According to Gurman et al. (1986), family therapy involves any psychotherapeutic endeavor that focuses explicitly on altering the interactions between or among family members and that seeks to improve the functioning of the family as a unit and as individual members. The goal of family therapy remains as above regardless of whether or not an individual in the family is identified as "the patient".

Because the focus of treatment is on all or most family members, family therapy is interpersonal in nature. It examines the process of communication within a family rather than merely the content of communication. Insight into intrapsychic processes is not considered important in family therapy (Haley, 1963). The focus is on understanding what is happening rather than on why and on modifying interactions so that the family can achieve balance and harmony. Family therapists tend to actively engage in intervention to achieve behavioral change.

"Schools" of family therapy reflect a wide range of theoretical orientations. These schools include psychoanalytic family therapy, experiential family therapy, behavioral family therapy, extended family systems therapy, communications family therapy, strategic family therapy, structural family therapy, and comparative family therapy. In their review of family therapies, Gurman et al. (1986) concluded that family therapy is probably at least as effective as, and possibly more effective than treatments commonly offered for problems attributed to family conflict. Family therapy has also been applied to a wide range of disorders of childhood, adolescence, and adulthood (Gurman et al., 1986). Space permits only a limited discussion of these systems of family therapy, but interested readers are referred to Erickson & Hogan (1981), Hoffman (1981), and Nichols (1984) for an overview of the field. Recent reviews of research on process and outcome in family and marital therapy are also available (Gurman et al, 1986; Kazdin, 1986).

Models of Family Therapy

Structural family therapy. Although there are many shared fundamental concepts among the various family therapies, there are also major differences in theory and practice. Structural family

therapy (Minuchin, 1974) seeks to change structures underlying family interactions. The therapist gathers information about the family and conceives a "structural map" of family interaction patterns. The therapist then actively participates in the family interaction as if he is a member of the family and learns, for example, what the subsystems within the family are, and who dominates the power structure. After understanding the family interaction pattern, the therapist seeks to change the pattern and its structure so that the family members will learn to behave more positively and supportively towards one another.

Strategic family therapy. In strategic family therapy (Watzlawick, Weakland, Fisch, 1974), the therapist treats the presenting problem instead of addressing hypothesized interaction patterns. Problems are believed to be the result of faulty life adjustments and continue due to the use of inappropriate solutions. There is disagreement among advocates of this school regarding the need for structural change in producing a successful outcome (Nichols, 1984). However, there is agreement on the basic goal of strategic therapy: to devise tactics that will outwit resistance and force people to behave differently. The solution is often, paradoxically, found in intensifying the problem through the technique of "prescribing the symptom". That is, clients are asked to maintain their symptoms in ways that will exacerbate them. In this way the symptoms come under the control of the therapist and are no longer controlled by the client. This enables the therapist to work more directly with the presenting symptoms in trying to change the problem behavior of the client.

Behavioral family therapy. Behavioral family therapy involves the application of classical and operant conditioning tailored to suit the needs of a family unit. Behavioral problems are believed to be the result of dysfunctional patterns of reinforcement within the family. In order to achieve the desired behavioral change, a functional analysis of behaviors is undertaken so that antecedents and consequences of the target behavior can be identified. Appropriate treatment programs in which the therapist directly manipulates contingencies and reinforcement are then implemented. Once the desired behavioral changes are achieved, family members are taught to modify their own contingencies of reinforcement so that the changes are maintained. The goals of therapy are to increase the rate of rewarding and positive interactions between family members by fostering positive behavioral change, to decrease the frequency of undesired behavior and the rate of aversive control, and to teach more effective communication and problem solving (Gurman & Knudson, 1978). This approach gives little attention to the bidirectionality of family interactions and it typically focuses on the subsystem within the family which is considered central to the targeted behavior.

Family Therapy and Ethnocultural Influences

In their review of family therapies, Gurman et al., (1986) concluded that family therapy is probably at least as effective as and possibly more effective than treatments commonly offered for problems attributed to family conflict. Family therapy has also been applied to a wide range of disorders of childhood, adolescence, and adulthood (Gurman et al., 1986).

Within the field of family therapy, there is a growing interest in addressing the issue of ethnocultural influences on family dynamics (McGoldrick, Pearce, & Giordano, 1982). Although accounts in the literature of family intervention with refugee are scarce, those reports which have appeared show that this approach can be successfully used with this population (Kim, 1985; Ko, 1986; Lappin & Scott, 1982; Tung, 1985). For example, Lappin and Scott (1982) treated a Vietnamese family who came to the attention of mental health professionals after social services and the police became involved with the children's problem behavior. Upon closer inspection, it was discovered that the mother was experiencing difficulties managing her four children and that the difficulties she faced were similar to those sometimes experienced by single-parent families. The mother, who did not speak English well, was emotionally and functionally dependent on her children. The therapists successfully used the mother's strength as a fluent Vietnamese speaker to demonstrate her competence to her children. This maneuver helped to reverse the role reversal and reestablished the mother's authority within her family. Once the family structure normalized, the mother was able to work through her grief, depression, and anger. The goals were specific, concrete, and short-term steps were used successfully.

Jung (1984) reported on the applicability of structural family therapy to Chinese families. He believes that a family approach is very appropriate for the Chinese because they perceive the individual as inextricably tied to his or her family. Changes in the individual without concomitant family involvement will only contribute to further alienation of the individual from his family. Jung believes that a structural approach is suited for Chinese families for several reasons. First, it emphasizes the social context in which families live and recognizes that new interaction patterns must be developed within the family system in order to promote gradual acculturation process. Second, the approach maintains appropriate generational boundaries, a prominent feature in the highly role-structured traditional Chinese family. Third, the process of "joining" enables the therapist to support each family member without alienating other family members. Each family member actually participates in the process of change, rather than just talking about change. Fourth, this treatment focuses on problem solving which will bring about change. Fifth, the structural approach builds on the strengths of families and, hence, is a positive approach. Finally, it is directive. The therapist asserts his or her expertise and authority, an approach to which the Chinese respond favorably.

Group Treatment

Group therapy has been used with Hispanics with some favorable outcomes (Comas-Diaz, 1981, 1985; Franklin & Kaufman, 1982; Hardy-Fanta & Montana, 1982; Olarte & Masnik, 1985). However, this approach is believed to be more difficult for Asian-Americans because of their reluctance to verbalize feelings in front of others (Kaneshige, 1973). A similar reluctance has been observed among Southeast Asian refugees making group therapy difficult to implement. Tung (1985) offers suggestions for making group therapy more effective with Southeast Asian refugees. First, the participants should be allowed to speak in their native language so that they may be less reluctant to speak in a foreign and difficult situation. Second, the group composition should be homogeneous with regard to their sex, occupation, social background and so forth. Third, treatment should be goal-specific and focused rather than process-oriented. Fourth, there should be a leader or a facilitator who is ideally one with experience, maturity, prestige, and social position.

Although scarce, there are reports of group therapy with Southeast Asians in the literature. Socialization groups and group therapy are offered at the Indochinese Psychiatric Clinic at the Oregon Health Sciences University (Jaranson & Bamford, 1987). The purpose of socialization groups is to educate clients about their illness, teach English and survival skills in America, and promote traditional activities such as cooking and telling folk stories. The groups are organized according to ethnicity and diagnosis, with diagnoses including depression, schizophrenia, and post traumatic stress disorder. For example, there are Cambodian women's post-traumatic stress disorder groups and Vietnamese women's depression groups. These weekly groups are co-led by an ethnic counselor and an American staff member, either a nurse, a social worker, or an occupational therapist. The clinic also implemented a once-a-month group therapy conducted by a psychiatrist and an ethnic counselor in which they focus on the traumatic refugee experiences.

At the Asian Pacific Counseling and Treatment Center in Los Angeles, various groups are offered (Yamamoto & Yap, 1984). Some groups are conducted only in Asian languages while others are conducted in both English and in Asian languages. There are groups for socialization, medication, support, and art therapy for chronically mentally ill clients. In these groups, patients can participate in organized activities and/or in formal discussions, depending upon the composition of the group members. In addition, there are other specialized groups, such as for battered wives, abused children, or relatives of clients.

TREATMENT APPROACHES DEVELOPED FOR MINORITIES AND REFUGEES

A brief presentation of some treatment approaches specifically developed for minority groups may aid some therapists in their attempts to adapt therapy for successful use with refugee populations. Matching treatment modalities through use of client variables has long been recognized as important for maximizing treatment effectiveness (Bergin & Lambert, 1978). Cultural background constitutes an important variable which needs to be considered in developing treatment modalities.

For Hispanic Americans, three approaches of culturally sensitive service delivery have been identified (Rogler, Blumenthal, Malgady, & Constantino, 1985). The first approach calls for increasing the accessibility of services by incorporating bilingual and bicultural staff into mental health facilities. This is based on the assumption that Hispanics will experience less cultural upheaval in seeking and remaining in treatment if ease of communication is assured. (Acosta & Cristo, 1981; Scott & Delgado, 1979). The second approach argues that the therapy Hispanics receive should be congruent with their culture or should be modified to include cultural values (Cohen, 1972; Padilla, Ruiz, & Alvarez, 1975). The third approach aims at addressing dysfunctional outcomes which accompany culturally prescribed behavior, such as "subassertiveness" among Mexican-Americans (Boulette, 1976).

Cuento Therapy

Hispanic children are at a high risk for developing mental disorders because of the multiple stressors present in their impoverished urban lifestyle and associated with their linguistic and ethnic minority status (Special Populations Task Panel on Mental Health of Hispanic Americans, 1978). Cuento therapy is an adaptation of a modeling therapy that is sensitive to the Hispanic culture. It was developed and used with Puerto Rican children (Constantino, Malgady, & Rogler, 1986). Cuentos, or folktales, often convey a message or a moral. The characters from cuentos are used therapeutically as models of adaptive emotional and behavioral functioning. Cuento therapy was evaluated by Constantino et al. (1986). Cuentos were either presented in their original form or rewritten to emphasize knowledge, values, and skills that are useful for coping with stress typically experienced by Puerto Rican children in this country. Changes reflect the settings and cultural values of American society, such that mango trees were changed to apple trees and rural plantations to urban playgrounds. They were also rewritten to stress certain themes, such as social judgement and delay of gratification. Bilingual-bicultural therapists and mothers read two cuentos bilingually, and then led a group discussion about the moral of the cuento. Next mother and child pairs role played the prominent behaviors within the story while being videotaped. The therapist reviewed the videotapes and summarized the adaptive and maladaptive consequences of the actions.

Children in two other treatment groups received either art/play therapy (Axline, 1947) or no intervention.

Results show that cuento therapy is effective in reducing trait anxiety, aggression, and improving social judgement among Puerto Rican children (Constantino, et al., 1986). First grade children in the adapted cuento group were less anxious after 20 weeks of therapy than those children in the original cuento or in play therapy groups. After one year, there were no differences in anxiety level between adapted and original cuento groups. Children in both versions of cuentos scored lower on ratings of aggression, though they did not differ from the no-intervention group. Furthermore, both cuento therapies enhanced children's WISC-R Comprehension subtest scores, suggesting that this approach helped improve children's ability to understand and evaluate socially learned information.

Ecological Structural Family Therapy

Ecological structural family therapy is of particular interest because it was developed especially for use with Cubans, who represent one of the United States' most prominent refugee groups. This approach was developed by Szapocznik and his associates, who suggest ecological structural family therapy (Aponte, 1974) as the treatment of choice for use with dysfunctional Cuban families (Szapocznik, Scopetta, & King, 1978). This approach represents an integration of ecological systems (Auerswald, 1971) and structural family therapy (Minuchin, 1974). Szapocznik and his associates suggest that therapy should be congruent with the client's culture and that cultural values should be mirrored in the structure of therapeutic assumptions. Ecological structural family therapy was adapted for use with Cubans based on the Cuban values of lineality within the hierarchical structure, subjugation to nature, present time orientation, and low-endorsement of idealized human values (Szapocznik, Scopetta, Aranalde, and Kurtines, 1978). These values have implications for culturally sensitive treatment. First, the therapist must validate the client's preference for a lineal style of relationship by relating to the client in a hierarchy, conveying to the client that the therapist is the one in a position of authority. Second, some Cubans tend to feel unable to control detrimental environmental circumstances. When environmental pressures appear to be the source of dysfunction, it may be fruitful to help reorganize the client's environmental resources. Third, Cubans generally enter into treatment because of crises (Szapocznik et al., 1978). The therapist must operate within the present time orientation and problem solve with the client. The therapist can capitalize on the crises to bring about change and restructure interpersonal relationship patterns. Fourth, the low-endorsement of idealized human values suggest that Cubans are unlikely to prefer treatment as a means of psychological growth, but rather would prefer pragmatic and concrete objectives.

According to the ecological structural family therapy approach, family problems in Cubans are primarily acculturation-related dysfunctions that are manifested within the family system (Szapocznik et al., 1978). Thus it is important to examine the effects of acculturation in terms of family systems model and to treat the family system rather than the individual. An ecological model of etiology and treatment is suggested since a shift in the person's position vis-a-vis his/her environment may also shift his/her experience. Therefore, an effective therapeutic approach must promote new interactions within the family and the extrafamilial environment so that each individual person in the family can experience more effective ways of dealing with the environment. Ecological structural family therapy attempts to help family members facilitate interaction within the family and also with their extrafamilial roles. Note that this work predates the Mariel boatlift of 1980, which consisted largely of single, low SES males, a number of whom were previously maladjusted. These findings may be less applicable to this recent group of arrivals.

As with other refugee groups, one of the major sources of family disruption for Cubans is intergenerational differences between traditional parents and the acculturated adolescents (Szapocznik et al., 1978). Parental authority is often questioned and the parents face marital tension which impedes effective parenting. Szapocznik et al. (1978) suggests that the therapist accept this organization and blends in with the family first, and then establish a strong alliance with the parents in order to reinforce their authority and clarify generational boundaries. Community agencies can be enlisted to assist in setting limits on the adolescent's problem behaviors. This strategy often helps lessen the gap between the family and the host community. In addition, the therapist assists in working out a more functional interaction pattern within the family and in reestablishing the parental role, in providing new peer relationships for the adolescent with the goal of discouraging antisocial behaviors, and in working out the marital conflict.

Family Effectiveness Training

Szapocznik and his colleagues have recently developed a more comprehensive family intervention-prevention program for use with Cuban families with pre-adolescents - Family Effectiveness Training (FET: Szapocznik, Rio, Perez-Vidal, Kurtines, Santisteban, 1986). This particular group was targeted because these children were believed to be at high risk for behavior problems because of current maladaptive family interaction patterns. FET includes an intervention component which aims at dealing with the existing structural family dysfunction, and a prevention component which is aimed at strengthening the family in enabling them to better deal with potential future stressors and conflict. The prevention aspect is structured as psychoeducational and it has two components. The family development component deals with intergenerational conflict by

developing communication skills, a concept of a healthy family, and the notion of taking responsibility and sharing. Drug education is also included here in order to help parents be well informed and enable the youth to perceive the parents as being able to provide guidance. The bicultural effectiveness training component deals with intercultural conflict, i.e., acculturation gap within the family. This conflict, which is frequently observed in refugee families, is managed by teaching the family bicultural skill and a transcultural perspective (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984). The bicultural effectiveness training provides the family with the understanding of cultural and developmental factors that pose difficulty for Hispanic families living in the U.S. It also help them prevent future intergenerational conflict by arranging structural changes within the family.

Life Enhancement Counseling

Szapocznik, Santisteban, Hervis, Spencer, & Kurtines (1981) report on life enhancement counseling approach for depressed Cuban-American elders, an refugee group. This approach was designed to enhance the meaningfulness of life for this specific age group through use of a culturally sensitive treatment model. The basic values of the Cuban group were identified, as discussed in above, (Szapocznik et al, 1978) and an appropriate approach was subsequently developed. Special considerations in applying those values to older people were made. One characteristic of older generations, their tendency to reminisce, was incorporated into the approach as a therapeutic strategy because of its spontaneity of occurrence and its ego-syntonic status. Another feature of this approach is the ecological model; the therapist had access to the elder's social environment that had created some of the social problems these elders experienced. In a study of the effectiveness of the life enhancement counseling approach, Szapocznik et al. (1981) found that the difficulties these elders experienced were amenable to psychosocial intervention, with or without pharmacotherapy. Those subjects who received both medication and life enhancement counseling made the most gains as compared to those who received either counseling or medication alone.

SUMMARY

Applying Western based psychological treatment approaches with refugees is often problematic because of language problems and cultural experiences. This paper explores factors that limit employing psychotherapeutic approaches with refugees and describes several techniques which appear to be promising for use with refugees

Crisis intervention is a potentially useful form of psychotherapy for refugees. Its highly structured and directed nature makes it less threatening to those who for cultural reasons are

intimidated by more intrusive forms of psychotherapy. By acknowledging the existence of a crisis, and identifying its precipitating factors, this form of therapy assigns a causal role to external rather than internal influences. This characteristic of crisis intervention may help alleviate some of the fears and culturally mediated negative connotations associated with the experience of emotional difficulties in some refugee cultures. Even the name crisis intervention may, for some groups, be less threatening than other forms of intervention containing the word therapy in their title.

Crisis intervention's time and goal limited nature also offer some important benefits for refugee psychotherapy. By clearly delineating the goals of intervention and the time frame within which these goals will be achieved, and by taking the lead and helping to maintain the focus of psychotherapy, the therapist offers his or her refugee client a sense of organization and order, in what otherwise might be a highly confusing and disorienting life situation.

The use of cognitive and behavioral techniques is a very promising new area in psychotherapy with refugees. The techniques are highly adaptable, rely on general principles of learning, involve continued monitoring of treatment progress, and rely on collaboration with the patient. Cognitive and behavioral therapies share important characteristics that meet the expectations of many refugee and minority clients; they are problem-focused, involve an active, authoritative therapist, and deal with concrete issues and solutions in life. The methods have been employed successfully in a variety of cultures, although not specifically with refugees. There is a great need for studies to clarify the strategies that should be employed when adapting such therapy for use with refugees, and to provide information regarding its effectiveness for differing disorders with persons from a variety of cultures.

Refugees often experience interpersonal difficulties as a result of, among other things, intergenerational conflict, marital conflict, and difficulties relating to their own ethnic community or to their new host community. There are a number of different approaches developed specifically to treat such interpersonal difficulties. These approaches can be categorized into individual, marital, and family therapy modalities with each modality consisting of further divergent theories and methods of treatment. Interpersonally oriented individual psychotherapies may be useful for addressing the unresolved grief that many refugees experience and for dealing with role transitions that are necessary to make when adjusting to life in a host country. These therapies can also be useful in learning more adaptive ways of interacting with others.

Marital therapies can be useful for dealing with increased tension and distress experienced among refugee couples. Therapists must be aware of the native marital roles and divergent cultural values, such as the acceptance of polygamy in some Southeast Asian cultures. Difficulties in disclosing intimate information may initially slow progress within these modalities. A problem

oriented approach in which the therapist takes an active role is often perceived as more helpful by refugee couples.

Family therapies can be appropriate and useful for dysfunctional refugee families because of the traditional emphasis refugees place on family balance, cohesiveness, and harmony. Some authors argue that treatment of an individual alone is countertherapeutic since individual treatment contributes to further alienation of the client from the family and that the involvement of the whole family is necessary for a successful outcome. When conducting family therapy, therapists must be aware of the structure of the refugee family and the importance of the extended family system. During treatment families may prefer to focus on the "identified patient" within the family and be reluctant to discuss wider family issues. As in marital therapy, concrete and pragmatic goals acceptable to the family and to the therapist can be pursued. This problem-solving approach is preferred by the refugees.

Several treatment approaches have been adapted for use with minorities. Therapies, such as Cuento therapy, which are congruent with the clients' cultural values have proven useful. Such culturally sensitive adaptations can be developed for refugee populations. Group therapy is often believed to be difficult with refugee clients who tend to be reluctant to express personal feelings in front of others. However, there are accounts of socialization, supportive, medication, and art groups for refugees which appear to show favorable results.

In conclusion, a variety of Western approaches to psychotherapy show promise for use with refugees. The crisis intervention, cognitive-behavioral, and family and interpersonal approaches discussed in this paper have promise when applied, with suitable modifications, to the varied refugee populations in this country. This promise is demonstrated both by their history of general cross-cultural application, and by their consistency with suggestions in the literature regarding characteristics that make psychotherapy effective and acceptable to refugees. The suggestions we have provided are of necessity only preliminary. There is a great need for practioners to continue adapting and applying techniques such as these in their work with refugees, and to report new ways of dealing with the many individual and cultural differences that occur within and between refugee groups.

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